

PN-ABR-942
ISBN 89206

HEALTH FINANCE DEVELOPMENT PROJECT

HFDP Monograph No. 6

August 1993



Department of Health
Republic of the Philippines

Prepared by Management Sciences for Health

Andersen Consulting

CARRA, Inc.

Harvard Institute for International
Development (HIID)

United States Agency for International
Development (USAID)

HEALTH INSURANCE IN THE PHILIPPINES

by
Rhais M. Gamboa
Ma. Cristina G. Bautista
Ma. Luisa I. Beringuela

LIST OF ABBREVIATIONS

LIST OF ABBREVIATIONS

AHMOPI	Association of Health Maintenance Organizations of the Philippines Inc.
CBA	Collective Bargaining Agreement
CPI	Consumer Price Index
CRC	Center for Research and Communication
DOH	Department of Health
DRG	Diagnosis-Related Groups
ECC	Employees Compensation Commission
EPI	Expanded Program on Immunization
GNP	Gross National Product
GSIS	Government Service Insurance System
HAAI	Health and Accident Insurance
HAMIS	Health and Management Information Systems
HEWSPECS	Health, Education, and Welfare Specialists Inc.
HFDP	Health Finance Development Project
HIF	Health Insurance Fund
HMO	Health Maintenance Organization
ILO	International Labor Organization
IPA	Individual Practice Association (HMO model)
IPI	Implicit Price Index
IRFI	Intercare Research Foundation Inc.
MSU	Medical Service Unit
NGO	Non-Governmental Organization
PAL	Philippine Airlines
PDMP	Philippine Airlines Dependents Medical Plan
PGP	Prepaid Group Practice (HMO model)
PHC	Primary Health Care
PMAP	Personnel Management Association of the Philippines
PMCC	Philippine Medical Care Commission
PMSU	Primary Medical Service Unit
PRC	Professional Regulation Commission
RVS	Relative Value Scale
SAHMO	San Antonio, Bifan, Health Maintenance Organization
SEC	Securities and Exchange Commission
SIF	State Insurance Fund
SSS	Social Security System
UP	University of the Philippines
UPHMO	University of the Philippines Diliman Health Maintenance Organization
USAID	United States Agency for International Development

P.N-ABR-942

HEALTH FINANCE DEVELOPMENT PROJECT

HFDP Monograph No. 6

August 1993



Department of Health
Republic of the Philippines

Prepared by Management Sciences for Health

Andersen Consulting

CARRA, Inc.

Harvard Institute for International
Development (HIID)

United States Agency for International
Development (USAID)

HEALTH INSURANCE IN THE PHILIPPINES

by
Rhais M. Gamboa
Ma. Cristina G. Bautista
Ma. Luisa I. Beringuela

A

HFDP Monograph No. 6

Health Insurance in the Philippines

**Rhais M. Gamboa
Ma. Christina G. Bautista
Ma. Luisa I. Beringuela**

Manila, 1993

**Health Finance Development Project
Project No. 492-0446**

Prepared under Contract No. 389-0249-C-00-1089-00. Edited and printed by Management Sciences for Health under Contract No. 492-0446-C-00-2114-00. The contract includes Management Sciences for Health and subcontracts with Andersen Consulting, CARRA, Inc., and the Harvard Institute for International Development (HIID).

This report was completed through the assistance of the United States Agency for International Development (USAID). The views, expressions, and opinions contained here are the authors' and are not intended as statements of policy of either USAID, the Department of Health, or the authors' parent institutions.

CONTENTS

Inside Front
Cover

LIST OF ABBREVIATIONS

- 1 EXECUTIVE SUMMARY**
Background 1/Overview of Health Insurance 1/The Medicare Program 1/ The EC Program 3/ Health Maintenance Organizations (HMOs) 4/ Commercial Indemnity Health Insurance 5/ Employer-Provided Health Benefits 6/ Community-Level Health Insurance 6/Conclusion 6
- 8 INTRODUCTION**
The Health Sector and the Economy 8/ The Health Finance Development Project (HFDP) 8/ Methodology and Limitations 9
- 10 OVERVIEW OF HEALTH INSURANCE**
Definition 10/ Forms of Health Insurance 10/ Types of Health Insurance Benefits 10/ Health Insurance Issues 11/ Health Insurance in the Philippines 12
- 13 THE PHILIPPINE MEDICAL CARE PROGRAM**
Program Overview 13/ Coverage and Membership Base 14/Beneficiaries and Program Utilization 15/ Contribution Structure, Collection, and Benefit Payments 16/ Financial Performance 18/Fund Utilization 21/ Support Value 21/ Medicare's Current and Potential Role in Philippine Health Care 23/ Areas for Further Consideration and Research 27
- 29 THE EMPLOYEES COMPENSATION COMMISSION**
Introduction 29/ Program Coverage 29/ Contributions and Benefit Payments 30/ Structure of ECC Benefits 30/ Fund Utilization 32/Financial Performance 34/ ECC's Role in Overall Health-Care Financing 34
- 36 HEALTH MAINTENANCE ORGANIZATIONS**
Introduction 36/ Investor-Based HMOs 36/ Community-Based HMOs 44/ Employer-Initiated HMOs 45/ Potential and Role of HMOs in Health-Care Financing 45/ Areas for Further Study 46
- 47 COMMERCIAL INDEMNITY HEALTH INSURANCE**
Introduction 47/ Health and Accident Insurance Companies 47/Gross Premiums Earned by Health Insurance Companies 48/ Gross Risks Taken by Health Insurance Companies 49/ Losses Taken by Health Insurance Companies 50/ Real Growth Rates of Gross Premiums and Losses 50/ Constraints on Individual Firms 51/ Industry Prospects 52
- 54 EMPLOYER-PROVIDED HEALTH BENEFITS**
Legally Mandated Benefits 54/ Health Benefits in Collective Bargaining Agreements 54/ Voluntarily Provided Health Benefits 56/Policy Implications 56
- 57 COMMUNITY-LEVEL INSURANCE**
Introduction 57/ The Philippine Experience 57
- 59 CONCLUSION**
- 61 REFERENCES**
- 63 ANNEXES**

C

EXECUTIVE SUMMARY

BACKGROUND

The Philippine health picture has improved significantly. Between 1970 and 1989, the crude death rate fell from 11.8 to 7.4 per 1,000 persons and life expectancy at birth rose from 58.1 to 64.4 years. Between 1975 and 1989, infant mortality dropped from 75 to 51.5 per 1,000 persons.

A rapidly growing population and a changing health profile (infectious diseases predominating and degenerative illnesses on the rise) continue to push the health sector to expand its services. But expanded health services require more resources which the government, in dire economic straits, can hardly be expected to provide fully. In 1990, the share of the Department of Health (DOH) in the government's total appropriations budget was 4.9%, down from the 5.9% of the previous year and the lowest since 1986.

The Health Finance Development Project (HFDP) was conceived by the DOH and the United States Agency for International Development (USAID) to meet the growing demand for preventive and curative services. The HFDP is premised on the generation of the needed additional resources from efficiency savings in the health sector, improvements in the incentive structure for health-care financing, and new financing mechanisms.

To develop the HFDP project paper, several studies had to be carried out to provide background information about the status, constraints, and prospects of health care financing in the Philippines. This paper is among those studies. It deals with health insurance in the Philippines and recommends various forms of assistance for its development.

This paper relied primarily on existing data, reports, and publications, interviews with key individuals, and the experience

and insights gained by the principal researcher from years of work with the Philippine Medical Care Commission (PMCC), the Employees Compensation Commission (ECC), and a health maintenance organization (HMO). The analyses were limited by outdated, inconsistent, possibly inaccurate data and by the short time allowed for the study.

OVERVIEW OF HEALTH INSURANCE

Health insurance is a means of prepaying for health care and spreading the risk of substantial medical care costs across a pool of potential patients. It can be provided by the government (through the Medicare program and ECC), private entities (such as the HMOs and private or commercial indemnity health insurance companies), employers, or preferred provider plans (such as community or cooperative schemes). The benefits can come in the form of health-care services or cash payments (sickness and maternity allowance and funeral grants).

The experience of other countries shows that insurance is availed of mostly by those above the poverty line and is most appropriate and affordable as part of an employee benefit package. The increased use of health-care services as a result of insurance also adds to health expenditures, and costs swell as insurance expands. Moreover, insurance can encourage providers to give suboptimal-quality service.

THE MEDICARE PROGRAM

The Medicare program is a compulsory health insurance scheme established by

Republic Act 6111 in August 1969 and implemented on January 1, 1972, with the creation of the PMCC. The PMCC, as a government agency, is supervised administratively by the DOH.

Medicare is being implemented in two stages. Program I, which initially covered only public- and private-sector employees and their dependents, now also includes retirees and the self-employed. Program II is intended for the informal sector but its implementation has been set back by financial and administrative difficulties. The DOH and the PMCC have lately begun basic research to help in resolving the policy and operating issues involved.

PMCC formulates policies and coordinates the implementation of Program I. The Social Security System (SSS) serves the needs of private-sector employees, while the Government Service Insurance System (GSIS) attends to state employees.

Of the 23.5 million Filipinos (38% of the total population) covered by Medicare in 1990, about 16.8 million were under SSS and 6.7 million under GSIS. In 1989, there were 4.6 million Medicare members, excluding dependents and retirees, or about 20% of the estimated 21.8 million people in the work force that year.

Despite its compulsory nature and the fact that it deals with the organized sector, Program I reaches only 20% of its target. This is partly explained by the structure of the labor force—45% are in agriculture, 39% in the service sector, and 16% in manufacturing. Implementing Program II appears to be an even tougher proposition.

Medicare currently provides in-patient benefits. Between 1972 and 1990, the rate of availing (beneficiaries served/total coverage x 100) for the entire program averaged 6.45%. SSS averaged 5.36%, almost half of GSIS' 10.36%. Several

reasons could account for the difference in availment rates. GSIS has covered retirees since 1974; SSS started doing so only in 1990. GSIS covers members of the Armed Forces of the Philippines and policemen, which are high-risk groups. Besides, the benefits provided by private employers, including pre-employment and annual medical checkups, may discourage their employees from claiming Medicare benefits.

Between 1987 and 1990, availment rates for both SSS and GSIS declined, indicating that the aggressive measures taken by the PMCC, SSS, and GSIS to curb abuse are beginning to work.

In 1990, SSS paid ₱710 million in benefits and GSIS, ₱442 million. The annual increase in benefit payments appears to be due to the spiraling cost of medical services rather than to increased availment rates.

Employee and employer share equally in the premium contribution to Medicare, at 2.5% of the salary base credit. The cap on contributions is a regressive feature. As a member earns more, his proportionate contribution decreases. In 1990, SSS collected ₱777 million in premiums, while the GSIS had ₱349 million.

Over the past several years, SSS has derived a sizable part of its total income from investments. In 1990, investment income was 52% of total income; collections accounted for the balance. GSIS, on the other hand, still relies heavily on premium collections, which made up 71% of its total income in 1990. The disparity in investment incomes between the two systems deserves scrutiny.

Premium contributions from members, earnings from investments, and other income, such as penalties on employers for delayed remittance of contributions, go into the health insurance fund (HIF, or reserves). SSS and GSIS have separate HIFs, from which they draw for benefit payments and operating expenses.

In 1990, SSS had reserves of ₱4.5 billion while the GSIS had ₱620 million. In terms of reserve capacity (number of years

current reserves can last, given current expenses), SSS had six years compared to GSIS' 1.4 years. Taken together, the two HIFs had a combined reserve capacity of 4.3 years in 1990. According to actuaries from two insurance companies, two to three years' reserve capacity for a health insurance program is safe.

Medicare support values, or the portion of hospitalization expenses paid for by Medicare, have fallen short of the targeted 70%. Between 1970 and 1989, they averaged from 32% to a peak of 49% in 1989. (As of the writing of this report, the support value corresponding to the 1991 benefit increases mandated by Executive Order 441 had not yet been determined.)

Medicare's present and likely role in Philippine health care can be assessed from the standpoint of the Medicare system itself and its impact on the health sector.

ASSESSMENT OF THE MEDICARE SYSTEM

Organizational Responsiveness

The fragmentation of responsibility for Medicare policy making and operation among three government agencies keeps Medicare from taking full advantage of economies of scale and from operating more efficiently. The possibility of placing the whole Medicare program under a single institution, which can retain the positive administrative features of the present system, should therefore be studied. SSS and GSIS may continue to collect premium contributions for a fee, while the designated institution, which can be SSS, GSIS, PMCC, or an entirely new body, can take care of policy making, fund management, and claims processing.

Financial Efficiency

This is defined as the ability to manage the HIF so that it can absorb benefit payments and other expenses. The SSS has done better than GSIS in this area. But what is at issue is the appropriate level of reserves, particularly for SSS. Is the six-year reserve capacity of SSS adequate or too much?

Should the stability or solvency of the program take precedence over responsiveness to the benefits needed by members? The PMCC must issue policy guidelines on this matter.

Operating Efficiency

This refers to the ability to detect and minimize fraud and needless use, and to process claims and reimburse providers quickly. Abuse of the program, although unquantified, could be significant. Efforts to curtail fraud should be strengthened and claims processing should be speeded up, particularly in the GSIS, which takes up to five or six months to process and settle claims.

Regulatory Influences

Under the Medicare law, the PMCC regulates only those providers that are accredited with the program. Therefore, until it is given the necessary legal authority, the PMCC cannot regulate HMOs as suggested by some quarters. And even with such a mandate, the PMCC still needs to develop the necessary manpower and systems. Moreover, its annual appropriation should be increased to reflect the added functions.

ASSESSMENT OF MEDICARE'S IMPACT ON THE HEALTH SECTOR

Ability to Act as a Risk-Sharing Mechanism

Medicare has allowed the formal sector and a segment of the self-employed to pool funds for the use of hospitalized members. It has also introduced the concept of cost sharing, wherein the member shares in the cost of his treatment. But Medicare does not yet cover all the employed and has yet to extend its benefits to the informal sector and to more of the self-employed.

Ability to Widen Access to Health Services

Medicare has given its members

financial access to health services, although not to the level of support value it aspires to. It has had mixed success in promoting equity. From the standpoint of premium cross-subsidy, equity is not served by the regressive structure of the premium contributions. But from the standpoint of the healthy members subsidizing the sick, or individuals without dependents supporting retirees or members with spouses and children, Medicare promotes equity.

Linking of Public Financing and Private Provision

Medicare has distinguished itself in this area. By design, the program taps both public and private providers. Moreover, the PMCC-HMO experimental tie-up project in Metro Manila, which expands the benefits of Medicare members at no extra cost to them, has drawn an impressive response from the members themselves. The project adds a new dimension to public- and private-sector coordination in health care.

Role in the Financing of Current and Future Needs

The extent to which Medicare can answer current and future needs rests on its ability to improve its benefit structure, make premium contributions more equitable, and strengthen its administrative and management systems. Its ability to help keep health-care costs from escalating and ensure the quality of health services seems limited at the moment.

Research can be carried out in the following areas of Medicare: enhanced benefits (such as higher support value and out-patient coverage); full coverage of the employed and those in the informal sector; the appropriate contribution structure and reserve levels; ways of containing costs, improving the quality of services, and maximizing use of medical resources; integration of the SSS and GSIS HIFs, including a suitable organizational structure; and an information system to strengthen policy making by the PMCC and make it better able to respond to the needs of Medicare members and service providers.

THE EC PROGRAM

The EC program, a compulsory social insurance program that gives tax-exempt benefits to employees or their dependents for work-related disability or death, was established by Presidential Decree 626 on December 27, 1974, and took effect on January 1, 1975, replacing the Workmen's Compensation. The benefits come in the form of cash in the case of disability or death, medical and related services for injury and sickness, and rehabilitation services in case of permanent disability.

The program is administered in much the same way as the Medicare program. The ECC sets policies, under the supervision of the Department of Labor and Employment. SSS and GSIS collect premiums and process and pay claims. They also manage separately two state insurance funds (SIFs) for privately employed workers and for state employees. But unlike the PMCC, which gets its institutional budget from the national government, the ECC depends on the two SIFs—60% of its institutional budget comes from the SIF managed by SSS and 40%, from the GSIS-managed SIF. An ECC official points to this dependence on the two systems as a major constraint on ECC operations.

ECC coverage is compulsory for all employees 60 years old and under. Older employees who have not been compulsorily retired and who have been paying contributions before the age of 60 may also be covered.

The roughly 12.2 million workers covered by the ECC in 1987 comprised 10.9 million SSS members and 1.2 million GSIS members, and represented about 21% of the Philippine population that year, versus 38% for Medicare. The fact that Medicare protection is extended not only to employees but also to their dependents, to retirees, and to a portion of the self-employed accounted for the higher percentage of people covered.

The ECC covered 59% of the employed in 1987. Medicare, which covers both the employed and the self-employed and so would be expected to include more people, covered only 22%. Only active members,

or those who pay their contributions regularly, are reflected in the reported coverage for Medicare. The ECC figure, on the other hand, may include inactive members whose names have not yet been dropped from the list.

The employer pays the entire ECC contribution but only half of the Medicare premium (the employee pays the other half). Under the EC program, private employers contribute a maximum of ₱10 per month per employee, while the government pays as much as ₱30 per employee. This disparity has to be reviewed.

In 1987, SSS membership contributions to the EC program amounted to ₱257 million, versus ₱217 million for the GSIS.

In 1988, GSIS far surpassed SSS in ECC benefit payments, ₱117 million versus SSS' ₱61 million. From 1975 to 1988, GSIS paid an average of ₱5,461 in benefits per claim, compared to ₱804 for the SSS. According to an ECC official, the disparity can be explained by GSIS' coverage of high-risk groups (policemen and members of the armed forces) and the more liberal benefit compensation formula prescribed by law for the GSIS. To improve equity, the difference in benefit computations between the GSIS and SSS should be resolved.

SSS had total ECC reserves of ₱3.9 billion in 1988, more than ten times the GSIS' ₱386 million, and had a reserve capacity of 59 years, compared to three years for the GSIS.

The high reserve capacity of SSS may require the ECC to make a crucial policy decision. It could decide to increase benefit levels substantially or to reduce premium contributions or to suspend premium collection for a while to give employers some relief in these difficult economic times.

The ECC could also consider designing and implementing an information system within the ECC and linking this with the SSS and GSIS systems; strengthening the ECC medical rehabilitation program and its contribution to occupational safety; and integrating the ECC medical, ambulatory,

and rehabilitative services with those of Medicare and concentrating instead on disability benefits.

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

HMOs commonly follow the prepaid group practice (PGP) model or the individual practice association (IPA) model. In the PGP model, salaried physicians serve full time or part time and share equipment and staff at the HMO facility, where they attend to enrollees. In the IPA model, enrollees receive care from the participating physician of their choice at his own office.

HMOs in the Philippines are investor-based, community-based, or employer-initiated. Investor-based HMOs, which combine features of the PGP and IPA models, are directed at the employed sector and are profit-oriented. Community-based HMOs are nonprofit experiments organized for lower-income communities. Companies form employer-initiated HMOs for their employees and sometimes also for their employees' dependents.

INVESTOR-BASED HMOs

- By various estimates, the Philippines has from 12 to 26 HMOs. (A 1990 study done by Andersen Consulting counted 16, excluding an HMO that started operating in the first quarter of 1991 in Olongapo City.) Anyone between the ages of 15 days and 65 years can be covered, although the HMOs may waive these limits in certain cases, particularly for corporate accounts. (The bias in favor of corporate accounts, plus the age requirement, is intended to limit the HMOs' actuarial risk.)
- Philippine HMOs market their products through individual agents, insurance brokers, or an in-house sales staff or a combination of these.
- An estimated 375,500, or about .63% of the population, were covered by HMOs in 1989. In the first quarter of 1991, the total enrolment was estimated at from

500,000 to 600,000, or about .81% to .97% of the 1990 population. No data exist to establish whether this significant increase in enrolment meant more people covered by some form of risk sharing or whether the increase meant a corresponding decline in commercial indemnity health insurance.

- HMO doctors are either paid regular salaries or accredited and compensated on a fee-for-service basis, at rates negotiated by the HMO with individual doctors. Salaried physicians serve at HMO-owned clinics, where medical consultations, minor operations, and diagnostic services are provided. (Each such clinic can cost as much as P3 million to put up.) Enrollees requiring diagnostic procedures or treatment that are not available in-house are referred to other clinics or hospitals or to accredited physicians. HMOs accredit clinics in strategic locations and in places where there are no HMO-owned facilities.
- HMO benefit packages commonly offer preventive health care (including annual physical checkups), in-patient services, out-patient services, and emergency care. "Pre-existing conditions" are excluded as a safeguard against adverse selection. Apart from the degree of actuarial risk, the type of room, the frequency of payment, the number of persons covered, and the supplemental benefits determine the fee charged for membership.
- Fifty-five percent to 60% of HMO revenues go to medical services, 15% to 20% to agents' commissions, 20% to administrative costs, and 10% to profits.
- HMOs cannot increase the membership fees of contracted clients to keep up with soaring hospital rates and are obliged to cope with a variety of other pressures, such as price cutting by competitors and the application of the value-added tax. What is more, some doctors are not favorably inclined toward HMOs, and many enrollees are unaware of HMO benefits. Some HMOs still have to arrive at the right mix of in-house marketing staff and outside agents.
- Currently, no government agency

regulates the HMOs in the country even if the HMOs themselves do not oppose regulation, provided it is not restrictive (what constitutes "restrictive" has to be defined). Regulation by the DOH or the Insurance Commission or the Securities and Exchange Commission was mentioned by some of the HMOs interviewed. Others proposed self-regulation by the HMO industry, with the DOH as the supervisor.

- Two foreign consultants suggested that a law regulating HMOs could define the role and functions of the HMO, include guarantees of mandatory dual choice and quality care, provide for redress of enrollees' complaints, prescribe enrolment practices, set the minimum level of benefits and pre-existing conditions, require the HMOs to maintain financial soundness and accountability, and create an advisory committee to evaluate consumer and provider complaints and review HMO regulations.
- Reacting to the proposed regulation, members of the Association of Health Maintenance Organizations of the Philippines Inc. (AHMOPI) contended that HMOs are not insurance companies and so must not be regulated as such, and that all regulations should be discussed with the HMOs. The AHMOPI members warned that regulations, if not properly considered, could raise membership fees excessively. Only regulations that are appropriate to the Philippines, they said, should be adopted.
- HMOs are generally sanguine about their growth prospects. Those interviewed foresee a yearly growth in enrolment ranging from 20% to 100% over the next few years. They suggested the following incentives to spur growth: legislation compelling employers to grant their employees mandatory dual choice between indemnity health insurance and HMOs; deductability of HMO membership fees from personal income tax; soft loans to new HMOs; tax-exempt importation of equipment; incentives for HMOs operating in the provinces; opening up of DOH hospitals to private HMOs and insurance companies, and of government facilities to HMO enrollees

who have exhausted their benefit ceilings; continuation of the Medicare-HMO tie-up in expanded form; official recognition of HMOs as supplementing Medicare and the ECC; and dialogue between HMOs and health providers, particularly in fee setting.

COMMUNITY-BASED HMOs

- Community-based HMOs are run like investor-based HMOs. The members pay a monthly fee for a specified set of in-patient and out-patient benefits, but there is a lower cap on these benefits than on those marketed by investor-based HMOs.
- A study entitled "Pilot-Testing of the Health Maintenance Organization as a Health Financing Scheme" was carried out by the Philippine Council for Health Research and Development, with support from the USAID. The study was made to determine whether prepaid managed care should be used to generate new financial resources for health at the community level, to give middle- and low-income families better access to health services. HEWSPECS and Intercare Research Foundation Inc. provided technical support in mobilizing communities and organizing HMOs.
- Two types of communities were chosen: a corporate community (University of the Philippines - Diliman) whose only health benefits were provided by Medicare, and a regular community (San Antonio, Bifan, Laguna) served by fee-for-service providers and government facilities.
- The San Antonio, Bifan, HMO (SAHMO) began in 1988 with 137 members. In 1990, the membership had increased to 400, most of these from households with monthly incomes below 2,000. The privately owned Perpetual Help Medical Center in Bifan, Laguna, admitted hospitalized cases. Out-patients consulted a doctor on retainer, who held office at specified hours at a public building.
- The UP Diliman HMO (UPHMO) began with 89 members in January 1989; by June 1990, total enrolment had reached

429. Its members had slightly higher incomes than SAHMO members. They could also choose among six hospitals.

- During the community experiment, consultations became markedly more frequent and more costly. Hospitalization frequency also rose sharply, but the periods of confinement were shorter and, in the case of the UPHMO, more likely to take place in a public hospital than previously. It was observed that HMOs cannot develop spontaneously in a community setting and have limited replicability. With the withdrawal of the external agencies that had helped develop the HMOs, the issue of sustainability also cropped up.
- SAHMO and UPHMO operations were observed for only a limited period, however, not long enough to make definite conclusions about the potential of community-based HMOs.

EMPLOYER-INITIATED HMOs

- The Philippine Airlines (PAL) set up the Philippine Airlines Dependents Medical Plan (PDMP) in February 1988 for the dependents of all regular PAL employees. Unlike investor-based HMOs, the PDMP is nonprofit and serves only PAL dependents. Its membership fees, which are subsidized by PAL, are lower than those charged by investor-based HMOs.

HMOs cover less than 1% of the population. Investor-based HMOs tend to favor the market segment that can afford to pay the premiums, to focus on group rather than individual accounts, and to exclude the elderly. In avoiding risk, the HMOs withhold coverage from some portions of the population, a situation health policy makers must consider in setting health-financing policies.

Among the studies or programs related to HMOs that can be carried out are consultations initiated by the DOH with all sectors affected by the proposed HMO regulation; pilot HMO schemes for the poor; formulation of a uniform relative value scale (RVS) for doctors' compensation, to

be used by Medicare, ECC, HMOs, and other institutions; linking of DOH public health programs with HMOs (as in family planning, immunization, and oral rehydration therapy); and assessment of the extent to which HMOs help contain health-care costs and provide quality care.

COMMERCIAL INDEMNITY HEALTH INSURANCE

In 1988, there were 102 companies involved in health and accident insurance (HAAI) in the country. Between 1975 and 1988, there were more nonlife insurance companies (92% of the total) than life insurance companies in HAAI. Domestic nonlife companies were most active (76%), followed by foreign nonlife (15%) and domestic life companies (7%).

Gross premiums collected by all insurance companies amounted to P469 million. Nominal gross premiums grew at an average of 20% from 1974 to 1988.

In 1988, life insurance companies sold P146 million in group health insurance, about 2.5 times the P58.5 million for ordinary insurance (including sales to individuals and families). Moreover, group insurance grew faster from 1974 to 1988, at an annual rate of 27%, compared to the 14% for ordinary HAAI. This predominance of group health insurance stems from the conscious effort of life insurance companies to focus on group accounts, which are considered less risky.

Gross risks represent the total potential amount in benefit payments (or total face value of policies issued) that the insurance companies contracted with their clients. In 1988, every peso of premium collected by nonlife insurance companies carried with it a P476 risk.

Losses refer to the amount of benefits paid by insurance companies. In 1988, the industry's total losses amounted to about P237 million—about 51% of the gross premiums collected that year, or P0.51 paid for every peso of premium earned.

The indemnity health insurance industry in the Philippines is growing very slowly in terms of people covered. Any growth in premium collection is essentially due to the higher premiums charged by insurance companies to cover increased health costs.

Officials of two life insurance companies selling HAAI disclosed that they consider health insurance an unprofitable product line and market it only to complete their array of insurance products. Another industry source intimated that his company would be happy with profits of 2% of premium from HAAI. In contrast, life insurance premiums yield profits of 10%.

HAAI companies are constrained by keen competition, high administrative costs, and the necessity of seeking clearance from the Insurance Commission for any increase in prices in response to rising health-care costs. They note that health insurance encourages people to have themselves hospitalized. The health insurance industry is also bugged by regulations that tend to treat health and accident insurance as similar to life insurance, a 15% premium tax that makes insurance coverage more expensive, and the absence of an association of HAAI companies where industry issues could be discussed.

Because of the generally low income of the majority of the population and the unprofitability of HAAI as a product line, the life insurance companies interviewed foresee no dramatic growth for commercial indemnity health insurance. Besides, hospital cash plans, which involve lower administrative costs, are being marketed more aggressively by their companies. There is also a growing clamor from labor unions for a comprehensive, HMO type of health benefit package.

The assessment of the two life insurance company officials, along with the analysis of nominal and real growth of premiums, would seem to indicate that commercial indemnity health insurance companies do not yet play a significant role in the financing of health services, particularly in widening coverage.

There are disturbing signs that one ill

effect of health insurance that Reinhardt noted in the United States is beginning to surface in the Philippines: the segmentation of the population, with insurance companies (including HMOs) focusing on the less risky groups.

EMPLOYER-PROVIDED HEALTH BENEFITS

Employers provide health benefits voluntarily or as required by law or collective bargaining agreements (CBAs).

Apart from Medicare and ECC, the Labor Code prescribes a minimum set of medical, dental, and occupational safety obligations for employers. The requirements vary, depending on the hazards in the work place and on the number of workers employed. At the lower end of the scale, first-aid treatment must be available within the premises. Larger companies, on the other hand, must provide a company clinic with a full-time doctor, nurse, and dentist.

CBAs also specify the medical benefits that companies must provide their employees and the employees' dependents. Different companies have different CBA provisions on medical benefits. Some employers without CBAs with their workers nevertheless provide medical benefits beyond the legally mandated.

The extent to which company-provided benefits contribute to the total cost of health services in the country should be studied. The research may include analyses of the benefits provided, by geographic area and industry sector; the ways in which companies are dealing with the rise in health-care costs; and possible links between DOH public health programs (such as family planning and AIDS control programs) and company health benefits.

COMMUNITY-LEVEL HEALTH INSURANCE

Community-level health insurance is a form of community health financing with

risk-sharing features. The donation of labor or materials for the construction of a health center is classified as community health financing. So is an exchange arrangement where individuals contribute an amount to a common fund in exchange for discounted medical services or drugs. But because of its risk-sharing element, the latter may be categorized as community-level health insurance.

In other countries, community-level health insurance is still in its infancy and its financial viability is doubtful. In the Philippines, the contribution of community-level insurance in particular and community financing in general to overall health care financing has yet to be determined. There are many community-level health insurance initiatives at the grassroots level, including those uncovered by the recent HAMIS contest held by the DOH and the German Agency for Technical Cooperation.

The DOH could consider defining a policy on the role of community-level financing in the overall health-care financing strategy of the country, considering the fact that community initiatives answer specific community needs and are possible because of particular community capabilities. The DOH policy need not be applicable nationwide. Instead, it can focus initially on activities in areas where the community has been mobilized and the organizational structure is in place.

CONCLUSION

Health insurance has helped make health services financially accessible to more of the employed and to the self-employed but not to all of these nor to all of the unemployed. Unfortunately, those not covered by insurance are at the lower economic levels of society.

In the interest of equity, the government must improve and expand health services to these underprivileged sectors. But all the resources required for such an objective cannot come from the government alone. Health insurance is one way of generating health funds. Insofar as it allows more people to be covered and

increases the support value of its benefits, then it makes the government's work easier for it.

Efforts to promote health insurance must be linked to an overall health-financing policy, since insurance affects service providers, cost escalation, and use of medical services, among others. However, since the Philippines is still developing its health-financing policy, policy makers must answer this question: Should health insurance be encouraged pending the announcement of such a policy? If so, how should such an activity be pursued without committing the country to a definite course of action from which it may have to veer in the future?

For instance, the current insurance practice is for doctors to be paid on a fee-for-service basis. In the future, the country could conceivably decide to pay them on a capitation or a global-budget basis. Encouraging the growth of insurance now—and, by implication, the present practices—could render policy changes more difficult later on.

Reinhardt says that policy makers must be guided as to the priority they should attach to each of the three objectives of a health-care system, namely: equity, freedom of providers in the pricing and practice of medicine, and economic and budgetary control. Otherwise, Reinhardt warns us, reform efforts will be wasted and

frustrating to all concerned, particularly since only two of the three objectives can be met at any one time.

Yet health-insurance programs are going concerns which cannot stop operating until a health-financing policy with clear objectives is formulated. Efforts to promote health insurance can stay relevant regardless of the health-financing policy adopted by focusing on activities that will boost efficiency and effectiveness, such as improving systems and procedures, training manpower, streamlining operations by containing costs and improving the quality of care, and pilot-testing public-financing strategies for low-income groups using private providers/insurers.

INTRODUCTION

THE HEALTH SECTOR AND THE ECONOMY

*Cured yesterday of my disease,
I died last night of the physician.*

- Matthew Prior

So might a patient wail, on learning his doctor's fees. Aside from its implied reproach of the fee-for-service arrangement and excessive costs in the health-care sector, the quote also points up the need for a health-care financing policy.

Filipinos are markedly healthier, according to the 1990 draft identification document for the USAID Health Finance Development Project. For every 1,000 people, the crude death rate fell from 11.8 in 1970 to 7.4 in 1989 and infant deaths dropped from 75.0 in 1975 to 51.5 in 1989. Moreover, between 1970 and 1989, life expectancy at birth rose from 58.1 to 64.3 years.

But rapid population growth and a shift in prevailing diseases from infectious to degenerative demand expanded health services—and more resources. By themselves, however, resources do not necessarily guarantee expanded services. Health services must also be made more efficient, effective, and equitable.

The need for expanded health services must be reconciled with harsh economic realities. Perennial fiscal deficits, balance-of-payments shortfalls, and an onerous debt (Solon *et al.* 1991) have checked growth, making the country less able to spend for health, and medical services even less affordable.

Tables 1 and 2 support these observations. Table 1 shows that the Department of Health's (DOH's) share of the overall government budget shrank to

only 4.9% in 1990 from the previous year's 5.8% and was at its smallest since 1985. Table 2, on the other hand, shows that the ₱1,723 per capita gross national product (GNP) in 1988 was lower than the 1980 GNP, and that the implicit price index (IPI) for medical services more than doubled between 1980 and 1988, from ₱296 to ₱781. In other words, income has not grown fast enough to keep pace with the increase in medical costs.

The aforementioned health gains achieved by the Philippines could therefore

be negated, unless health resources are used more effectively.

THE HEALTH FINANCE DEVELOPMENT PROJECT (HFDP)

The HFDP was designed to ensure that there are enough resources to meet the growing demand for preventive and curative services. As the government cannot be expected to increase the health budget

Table 1 DOH Budget vs. General Appropriations Act (GAA) (in Billion Pesos)

Year	DOH-Authorized Appropriations (₱)	GAA (₱)	% of DOH Budget to GAA
1980	1.4	37.9	3.7
1981	1.8	50.3	3.6
1982	2.1	57.1	3.7
1983	2.7	61.8	4.4
1984	2.3	53.5	4.3
1985	2.4	58.3	4.1
1986	3.4	67.4	5.0
1987	4.3	79.3	5.4
1988	5.0	87.5	5.7
1989	6.9	117.0	5.9
1990	7.6	156.5	4.9

Source: Department of Health

Table 2 Some Economic Indicators Relevant to the Philippine Health Sector

Year	Per Capita GNP (1972 pesos)	Implicit Price Index for Medical Services (1972=100)
1980	1,915.14	296.71
1981	1,932.45	337.86
1982	1,920.82	384.61
1983	1,894.53	432.63
1984	1,717.88	560.94
1985	1,607.31	648.84
1986	1,600.14	695.66
1987	1,650.71	737.62
1988	1,723.11	781.33

Source: Solon and Herrin 1991

anytime soon, HFDP is premised on the generation of the needed resources from efficiency savings within the sector, improved incentives for health-care financing, and new private-sector investments.

To develop the HFDP project paper, several studies had to be carried out to provide background information about the status, constraints, and prospects of health-care financing in the Philippines. This paper on health insurance in the Philippines is among those studies.

METHODOLOGY AND LIMITATIONS

METHODOLOGY

This paper relied primarily on secondary data, interviews with key individuals, and the experience and insights gained by the principal researcher from

years of work with the Philippine Medical Care Commission (PMCC), the Employees Compensation Commission (ECC), and a health maintenance organization (HMO).

LIMITATIONS

This paper is limited by the following:

- **Lack of data.** The discussion on HMOs does not include analyses of utilization and financial data, which the HMOs were generally reluctant to share. The information about the present number of enrollees was based on interviewees' estimates rather than on official documents. Only a few HMOs had filed updated financial reports with the Securities and Exchange Commission (SEC) at the time of inquiry, so this paper had to rely heavily on the work of Alfiler (1989). The cost, utilization, and other operating data that members of the Association of Health Maintenance Organizations of the Philippines Inc. (AHMOPI) have recently agreed to

provide to Andersen Consulting constitute probably the first updated information about HMOs in the country.

Also for lack of data, the coverage and value of company-financed benefits and community-level financing could not be analyzed.

- **Data accuracy and completeness.** The data may be incomplete or inaccurate in some cases. For instance, the records of the Insurance Commission show that life insurance companies made no medical insurance payments (zero losses) in 1981 and 1983. This is highly improbable. Also, some Medicare data obtained by the researcher from the PMCC do not tally with data found in the *CRC Health Care Factbook*, which were derived from the same source. Such discrepancies will not, however, substantially change the observations made in this paper, particularly the trend analyses.

OVERVIEW OF HEALTH INSURANCE

DEFINITION

Health insurance is defined as "a means of prepaying for health care and spreading the risk of substantial medical care costs across a pool of potential patients" (Lewis 1988).

An individual usually seeks health insurance and agrees to pay a regular fee, or premium, to an insurance firm to protect himself from the full brunt of medical care—preventive or curative—that he may need in the future. He thus averts what could be devastating financial consequences. Medical debts accounted for 60% of involuntary sales of land, in a Thai study cited by Abel-Smith (Cooper 1990).

When a group of people with varying probabilities of getting sick pool their risks and premiums, each individual in the group gets even greater financial protection. The more people there are in the group, the more likely it is that their combined premiums will be enough to cover their individual expenses (Ron *et al.* 1990). In a sense, therefore, insurance is risk transfer: the person buying insurance passes on his risk to the group or the insurance company (Alfiler 1989b).

Akin contends that risk sharing is most valuable when the insured event is rare, largely unpredictable, and very costly, and the individual is disposed to pay for protection. It is not economical, Akin adds, for predictable illnesses that are moderately costly since these bear no risk. Paying the administrative costs through an insurer makes little sense, particularly when all the insured will claim for the same predictable illnesses (Lewis 1988).

Health insurance exists because people are generally dissatisfied with the quality and quantity of curative services provided by the government and yet are increasingly

unable to afford private medical services (Ron *et al.* 1990).

FORMS OF HEALTH INSURANCE

Health insurance takes the following forms (Saunders 1989):

- **Government-sponsored insurance**, which is normally compulsory and associated with social health insurance. In the Philippines, the Medicare program and the ECC fall under this category.
- **Private insurance**, for individuals or groups who are willing and able to pay for private health services. Included here are HMOs and private or commercial indemnity health insurance companies.
- **Employer-provided**, through in-house health facilities or through contracted health-care providers or organized prepayment groups.
- **Preferred provider plans**, including community or cooperative schemes where health services can be availed of by members, who pay or contribute an amount.

Compulsory health insurance, by virtue of its compulsory nature and wider coverage, fulfills a clear social purpose and is therefore also known as social insurance. As the Latin American experience has shown, it serves to broaden the hospital-based system (World Bank 1987).

Because good and bad risks are shared and resources pooled, financial viability is more likely when participation is compulsory than when it is voluntary. (Private or commercial insurance companies, in contrast, compute insurance premiums on the basis of individual risk.)

In developing countries, the availability of doctors, other paramedical staff, and appropriate health infrastructure (such as buildings, pharmaceuticals, supplies, equipment, and transport) are as essential to the viability of compulsory health insurance as the concept of social solidarity (Ron *et al.* 1990).

Social insurance is generally limited to workers in the wage sector and their dependents, and unfortunately excludes the poorest occupational groups such as farmers, domestic servants, and agricultural workers.

TYPES OF HEALTH INSURANCE BENEFITS

Ron *et al.* (1990) classified health insurance benefits as follows:

- **Health-care (in-patient and out-patient) services to individuals.** Services to the community as a whole (such as vector control and environmental sanitation) are excluded.
- **Cash payments**, which are allowances or compensation for lost income. They exclude payments by the insured to the provider of service. Cash payments can take any of the following forms:
 - **Sickness allowance**, a fixed percentage of the daily wage of the insured paid to him for a specific period to compensate him for the income lost because of illness. A waiting period normally precedes the first payment.
 - **Maternity allowance**, a fixed percentage of the daily wage of the insured paid to her for a limited period during confinement to cover the income lost during the

maternity leave.

Funeral grant, a lump sum paid to the legal survivors of the deceased insured to cover funeral expenses.

HEALTH INSURANCE ISSUES

IMPACT ON THE HEALTH SECTOR

Health insurance is deemed useful only for those above the poverty line and is most appropriate and affordable as part of a package of employee benefits. In the U.S., the rapid expansion of health insurance coverage accompanied the growth of an industrially employed middle class and, according to Lewis (1988), made the high cost of technology affordable.

In addition, health insurance increases the use of health-care services and consequently adds to health expenditures, leads to cost inflation as coverage expands, and may encourage providers to give suboptimal-quality services (Alfiler 1989).

HEALTH INSURANCE RESTRAINTS

Akin (Lewis 1988) links the rate of growth of private insurance in a developing country like the Philippines to the following factors:

- **Low incomes.** Survival is the highest priority for households, which therefore choose to face the financial risk of illness. Agreeing with Akin's view, Abel-Smith and Dina (Lewis 1988) point out that at the community level, where earnings depend on agricultural cycles and discretionary income is meager, households are loath to join prepaid schemes because the returns are not immediate and are not assured. While this contention seems to be challenged by some experience in Nepal, there is as yet insufficient evidence to settle the issue.

- **High administrative costs and complex operation.** The costs associated with organization, monitoring, processing, and claims payment can be substantial. Poor infrastructure (such as communications network) within the country and lack of managerial skills may compound the problem.

- **Availability of free health care.** If health services can be had for free, from government or charitable institutions, people may not feel compelled to look for other means of health financing.

- **Ability to pay for catastrophic care in the absence of free health services.** As a rule, people try to generate the resources needed to settle their bills. If they can raise the funds, they may not buy insurance.

- **Lack of consumer awareness of insurance benefits.** Not knowing what benefits insurance provides, where insurance can be bought, and how it is used, people may fail to appreciate the value of insurance and not want it for themselves.

- **Macroeconomic, legal, political, and financial factors,** including high interest rates, high inflation rates, high exchange rates, and legal restrictions. Legal or political factors, such as the tax incentives provided by the U.S. government in the 1950s, which excluded company health insurance benefits from taxable income, can favor the growth of health insurance (Lewis 1988). On the other hand, limited growth is projected in the near future for health insurance in developing countries, where austerity measures may curtail health allocations (World Bank 1987).

During a conference on health care financing policy in Manila on March 22, 1991, Dr. William Hsiao identified the following preconditions to effective implementation of health insurance:

- Economic organizations
- Adequately trained insurance experts and managers

- Clear standards for qualified hospitals, doctors, and pharmacies
- Well-established accounting and clinical record systems, to allow verification of billed services
- Regulations against the practice of risk selection (skimming the cream)
- Laws to reduce kickbacks and ensure drug safety
- Rational payment systems for hospitals, physicians, and drugs

FACTORS AFFECTING THE VIABILITY OF HEALTH INSURANCE

Apart from these obstacles, two difficult problems stand in the way of viable operations (Saunders 1990). These are:

- **Adverse selection.** Sick individuals or those who are likely to get sick may enrol in disproportionately great numbers so that the total premiums collected may not be enough to pay for all the medical costs of the sick. To avoid this problem of adverse selection, insurance companies choose not to cover sick people and concentrate instead on the healthy. As will be discussed in a later section, this strategy creates a problem for society as a whole, as has been experienced in the U.S.
- **Moral hazard.** This occurs when there are no obstacles or disincentives to the overuse of health services, and individuals are encouraged, particularly where health services are free, to consume services more frequently than necessary, to the point of overconsumption. Deductibles and co-insurance may be introduced to solve this problem, but such barriers may also unduly deter patients from seeking medical attention until their condition worsens and more expensive treatment is required. Developing countries may be hard put to deal with the higher demand for health services and steep rise in service costs that result from moral hazard.

HEALTH INSURANCE IN THE PHILIPPINES

Table 3 shows that in 1985 only 4.1% of Philippine health expenditures went to health insurance. Compulsory health insurance (Medicare and EC) accounted for 3 percentage points, while private health insurance (including HMOs) made up the balance. As a whole, health insurance was not yet a significant financing source.

The table also shows that government (the first three sources) supported more than 24% of health-care expenditures and private sources (the last three sources) funded 74%, or more than three times the government's share.

The category "Others" refers to company-financed health benefits,

Table 3 Source of Funds for Health Care Expenditures, 1985

Sources	Amount (in Billion Pesos)	% Share
Taxes	2.85	19.6
Government Operating Income	0.10	1.1
Local Aid	0.50	3.4
Foreign Assistance	0.27	1.8
Household Spending	5.37	36.9
Insurance Benefits	0.60	4.1
Others (Private)	4.80	33.1
Total	14.55	100.0

Source: *Intercare 1987*

community-operated health funds, and philanthropic assistance to indigent patients. It represents a significant source of financing and for this reason merits closer attention.

The category "Household Spending" includes out-of-pocket payments by individuals to service providers. It is the single biggest source of health funds.

THE PHILIPPINE MEDICAL CARE PROGRAM

PROGRAM OVERVIEW

PROGRAM OBJECTIVES

R.A. 6111, otherwise known as the Philippine Medical Care Plan (Medicare Program), set up the country's national social insurance program in August 1969. But the program was implemented only on January 1, 1972, with the creation of the Philippine Medical Care Commission (PMCC).

As a matter of policy, Medicare is committed to providing comprehensive medical care to Filipinos in a gradual and evolutionary manner consistent with the nation's ability to pay, recognizing that the patient must share in the financial burden of the medical services he obtains.

This implicit cost-sharing concept was qualified by the 1986 Constitution, which recognized that certain members of society are too poor to pay for their health needs. Apart from naming these priority sectors (the underprivileged, the sick, the elderly, the disabled, women, and children), the Constitution also provided for free medical care to indigents (Article XIII, Section 11). This provision will have to be taken into account in deciding on the directions of Medicare Program II.

PROGRAM IMPLEMENTATION

Because of expected policy and operational difficulties, Medicare is being implemented in two stages. The idea is to gain experience from the first stage (Program I) before going on to the more complicated second stage (Program II). Program II is still to be implemented, although the DOH and PMCC have taken the initiative to carry out the basic research necessary to decide on the policy and operating issues involved.

Program I, which initially extended compulsory medical insurance only to public-sector and private-sector employees and their dependents, now also includes retirees (since 1974 for GSIS and since 1990 for SSS) and the self-employed (on a voluntary basis since 1983 for SSS).

Program I currently provides in-patient medical benefits. There are maximum peso allowances for each type of hospital service (room and board, medical, operating room use) and each hospital category (primary, secondary, or tertiary). The type of illness—

surgical or nonsurgical—determines professional compensation. A surgeon is paid according to a relative value scale (RVS) developed by the PMCC; an anesthesiologist earns a third as much. A nonsurgeon gets a fixed amount per day, which is higher for specialists accredited by medical specialty societies than for general practitioners.

Table 4 presents the current Medicare benefits. Medical expenses in excess of those benefits are shouldered by the patient. Medicare does not cover out-patient

Table 4 Schedule of Benefits for Medicare Beneficiaries Under E.O. 441 (as of January 1, 1991)

Services	Type of Hospital		
	Primary P	Secondary P	Tertiary P
Room and Board	45	80	100
Drugs per Confinement Period			
Ordinary cases	495	660	705
Intensive cases	337.50	1,125	2,205
Catastrophic cases		2,535	2,895
Laboratories/X-ray per Confinement Period			
Ordinary cases	105	250	440
Intensive cases	225	575	875
Catastrophic cases		1,125	2,670
Professional Fee Maximum			
Ordinary cases			
General practitioner	250	250	250
Specialist	375	375	375
Intensive/Catastrophic			
General practitioner	375	375	375
Specialist	625	625	625
Surgeon's Fee According to RUV Scale, Not to Exceed P5,900			
Anesthesiologist's Fee Not to Exceed P1,770			
Operating Room Fee According to RUV Bracket			
RUV 5 and below	115	205	325
RUV 5.1 - 10		350	415
RUV 10.1 and above		800	1,075
Family Planning Procedures			
Vasectomy	250	250	250
Tubal ligation	400	400	400

Source: Philippine Medical Care Commission, *The Medicare Primer*

services, cosmetic and optometric services, normal obstetrical care, mental illness, and rehabilitative services performed outside the hospital. Over the years, Medicare has increased its benefits. While reimbursements for various benefit categories and fee values increased over the last three years, however, the benefit structure has remained the same.

Program I benefits are financed through compulsory contributions collected through a payroll tax. Each employee contributes 2.5% of his salary base, and employer and employee share equally in the cost. Beyond the salary base ceiling, contributions are the same, regardless of salary. This ceiling was reset in 1978, 1986, and 1989. It was P2,000 at the time of this study and will rise to P3,000 in 1993.

Figure 1 is a sketch of the Medicare system. Medicare benefits can be availed of at all public and private hospitals and drugstores and with all doctors and dentists accredited by PMCC. After using health services, the beneficiary files a Medicare claim form with the hospital, which then requests reimbursement from SSS or GSIS. If the claim is in order, the provider is reimbursed according to the prevailing benefit limits. On the average, counting from the time the system receives the claim to the point the reimbursement check is mailed to the provider, SSS settles claims within 30 days, while the GSIS takes up to four or five months. Delayed reimbursement, particularly for the GSIS which has not followed SSS' lead and decentralized claims processing to the regions, is a source of frequent complaints

among service providers.

As provided for in the Medicare law, the PMCC promulgates rules and regulations to implement the Medicare program, monitors cases of abuse, conducts information campaigns, does research on the support value of Medicare benefits, and recommends premium payments and benefit packages. It is governed by a board of commissioners headed by the DOH secretary and a DOH undersecretary, with the following as members: the SSS administrator, the GSIS general manager, the secretaries of labor, finance, and local government, and a representative each from the hospitals, doctors, beneficiaries, and employees. Executive Order 105 in 1986 made the DOH secretary PMCC chairman, and a DOH undersecretary vice chairman, to coordinate PMCC health financing activities with the overall health financing and delivery efforts of the DOH. The PMCC's institutional budget for salaries, operating expenses, and capital outlays comes from the annual appropriations of the national government.

Also in accordance with the Medicare law, members' contributions are collected, managed, and disbursed by the SSS for private-sector employees and the GSIS for government employees. These contributions, together with the income accruing to them, make up two separate and distinct Health Insurance Funds (HIFs, or reserves). The Medicare law likewise allows each system to charge against its HIF all benefit payments and operating expenses it incurs in implementing the Medicare program, provided the charges do not exceed 12% of the contributions and investment earnings.

COVERAGE AND MEMBERSHIP BASE

Table 5 on the next page shows the Medicare membership (those paying premiums) and program coverage (premium payers and their dependents, retirees, and voluntary enrollees among the self-employed) between 1972 and 1990. In 1990, the program covered 23.5 million, or 38% of all Filipinos.

Fig. 1 The Medicare System

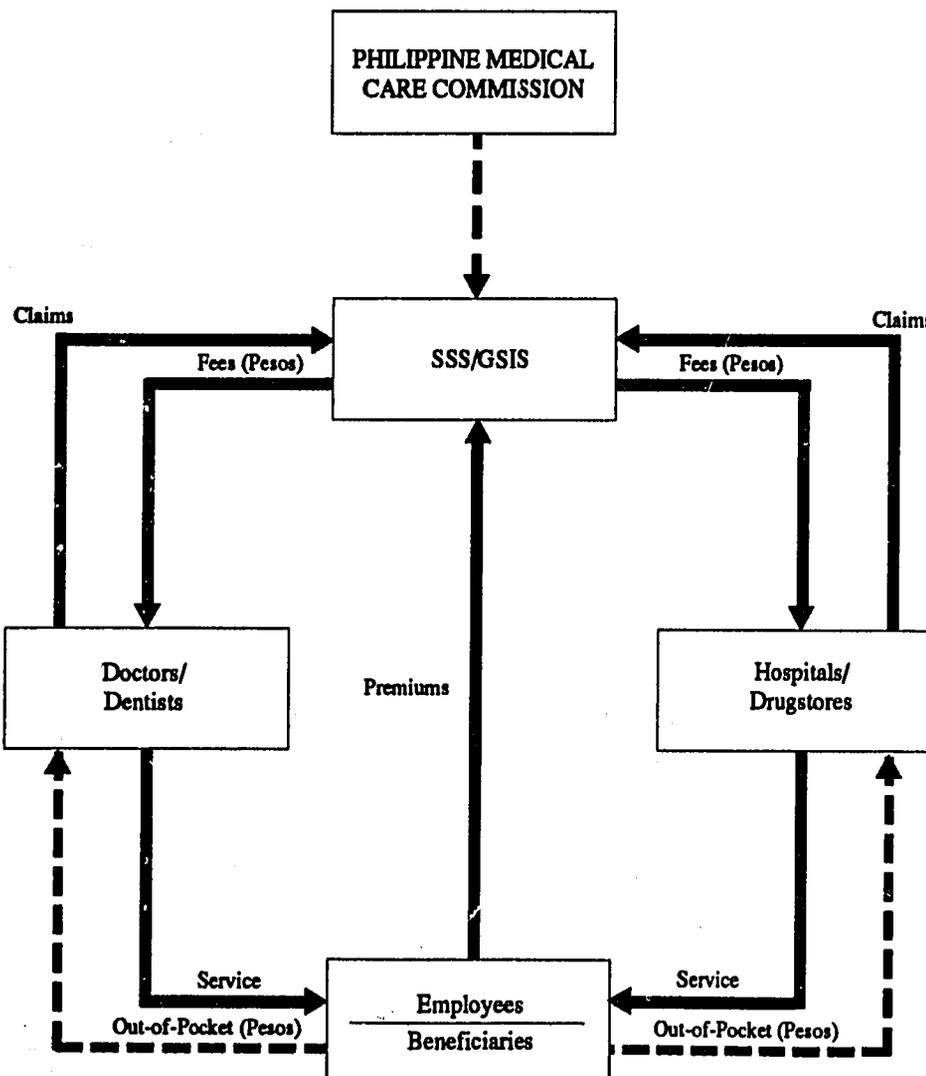


Table 5 Medicare Program Coverage, 1972-91

Year	Coverage*		Coverage Distribution		Members**			Total Employed (Millions)	Members as % of Employed	No. of Dependents and Retirees (Millions)	Dependency Rate***
	Total No. (Millions)	As % of Population	% SSS	% GSIS	SSS (Millions)	GSIS (Millions)	Total (Millions)				
1972	5.59	14.40	90.90	9.10	1.27	0.51	1.78	12.50	14.24	-	-
1973	8.47	21.00	75.80	24.20	1.61	0.51	2.12	13.90	15.25	1.54	0.73
1974	9.25	22.50	75.90	24.10	1.75	0.53	2.28	13.80	16.52	1.70	0.75
1975	10.99	26.10	73.20	26.80	2.01	0.71	2.72	14.50	18.76	2.23	0.82
1976	12.42	28.60	73.80	26.20	2.29	0.79	3.08	14.20	21.69	2.47	0.80
1977	13.54	30.40	74.50	25.40	2.52	0.83	3.35	14.30	23.43	2.62	0.78
1978	14.72	32.10	75.40	24.60	2.78	0.87	3.65	16.10	22.67	2.75	0.75
1979	16.01	34.00	75.60	24.40	3.03	0.94	3.97	16.20	24.51	2.97	0.75
1980	17.56	36.50	75.30	24.70	3.30	1.05	4.35	16.40	26.52	3.29	0.76
1981	18.40	37.10	76.10	23.90	3.50	1.06	4.56	17.40	26.21	3.34	0.73
1982	19.53	38.50	75.80	24.20	3.70	1.14	4.84	17.30	27.98	3.58	0.74
1983	21.32	41.00	76.60	23.40	4.24	1.20	5.44	19.20	28.33	3.79	0.70
1984	27.63	51.80	76.40	23.60	4.41	1.28	5.69	19.60	29.03	5.23	0.92
1985	29.06	53.20	74.30	25.70	4.51	1.47	5.98	19.80	30.20	6.00	1.00
1986	29.77	53.20	75.90	24.10	4.72	1.39	6.11	20.50	29.80	5.79	0.95
1987	21.84	38.10	69.30	30.70	3.24	1.28	4.52	20.80	21.73	5.42	1.20
1988	22.23	37.90	69.10	30.10	3.32	1.28	4.60	21.40	21.50	5.42	1.18
1989	22.44	37.40	70.10	29.20	3.38	1.25	4.63	21.80	19.95	5.31	1.15
1990	23.47	38.20	71.40	28.60	3.78	1.28	5.06			5.58	1.10
1991****	24.21	38.50	71.60	28.40	3.87	1.30	5.17			5.89	1.14

*Includes members, retirees, self-employed, and dependents

**Premium payers (dependents and retirees excluded)

***Dependency Rate = (Dependents+Retirees)/Members

****Projected

Source: Philippine Medical Care Commission

Between 1972 and 1990, the proportion of the population entitled to Medicare support grew at an average of 9% yearly, rising from 14.4% in 1972 to a peak of 53% in 1985 and 1986 before settling at around 38%. The significant decline in coverage between 1986 and 1987, from 53.2% to 38.1%, could be due to the purging of inactive members from the SSS files and to the government reorganization at the time.

Around two-thirds of the Medicare population are employed in the private sector—16.75 million versus only 6.72 million from the public sector in 1990.

Over the past three years, Medicare membership has been limited to only about a fifth of all the employed. In the mid-1980s, about a third were members. (Because of differences in reference periods, especially for the late seventies and for the years since 1987, these employment figures may not be fully comparable.) Earlier estimates of coverage ranged from a third to nearly half of total employment between 1972 and 1982 (Griffin 1985).

The large numbers of the employed who are not PMCC members, despite the compulsory nature of Program I and an established administrative structure, indicate that it may be even more difficult to extend Program II to the nonformal sectors. Program I still does not cover all private-sector employees, possibly because of the structure of the labor force, where 45% are in agriculture, 39% in services, and only 16% in manufacturing where compliance is expected to be higher (ILO 1990). The present information unfortunately does not classify membership by sector of employment. Otherwise, the formal employment sectors that show poor compliance with Medicare membership requirements could be identified.

In absolute terms, the number of dependents and retirees has been increasing. The needs of this dependent group will have to be met by fund reserves if premium collections can cover only the members' service costs. Alternatively, the members may have to pay higher premiums. The dependency rate, or the degree to which

members support dependents and retirees, remains low but it is rising.

BENEFICIARIES AND PROGRAM UTILIZATION

Table 6 on page 16 shows that a growing number of persons have been claiming reimbursements for hospitalization. Of the 1.2 million Medicare beneficiaries in 1990, 56% were SSS members.

But while more SSS members than GSIS members availed of benefits, SSS beneficiaries registered an availment rate of only about 5%, on the average, versus 10% for GSIS members. The differing membership profiles of the two systems may account partly for the difference in availment rates. Many private companies also offer their employees medical services (such as pre-employment and annual medical checkups) and facilities, and more liberal hospitalization benefits than those provided by the Medicare program. In

addition, GSIS covers high-risk groups such as policemen, the military, and retirees. (As has been mentioned, GSIS has covered retirees since 1974, while SSS started doing so only in 1990.)

The declining availment rates over the past three years perhaps also confirms the program's success in checking abuse in the reimbursement process.

The overall average program availment rate of 6.5% compares favorably with the 6.8% national hospitalization rate of one of the largest HMOs. However, in Metro Manila where availment controls are better, the same HMO has a 4.6% hospitalization rate, implying that Medicare costs overall can be cut with better controls.

CONTRIBUTION STRUCTURE, COLLECTION, AND BENEFIT PAYMENTS

The health insurance program is funded by the compulsory payroll contributions of members and their employers. Table 7 shows the planned structure of contributions according to earning classes based on the 1989 adjustments. The maximum contribution base has changed only three times—from ₱300 in 1972 to ₱600 in 1978 and ₱1,000 in 1986. The 1989 adjustments, which are scheduled to take effect this year, prompted the third change. The maximum salary base will be ₱2,000 in 1991, ₱2,500 in 1992, and ₱3,000 in 1993.

However, there is a cap on contributions at which level they remain the same despite increases in salary. This is a regressive feature. An individual's proportionate contribution to the fund goes down as his earnings go up.

Table 8 on page 17 shows that collection income has been increasing in absolute amounts and that the rate of increase over the past five years averaged 19%, following a period of slow growth. The increase was most dramatic immediately after 1972, 1978, and 1986, when the maximum contribution base was reset, indicating that premium contributions, much more than

increases in the membership base, drive up collection income. The downward trend in premium collections in 1990 is perplexing, following as it did on the 1989 adjustments. A likely explanation could be the economic downturn in 1990, which slowed down contributions.

Overall, benefit payments have been rising much faster than collection income, registering an annual average rate of change of 40% compared to the 15% growth in collection income. Despite the observed decline in rate of availment, benefit payments jumped up by 58.7% in 1990.

Table 6 Beneficiaries Served and Availment Rate, 1972-91

Year	SSS		GSIS		Total Medicare	
	No. of Beneficiaries Served*	Availment Rate**	No. of Beneficiaries Served	Availment Rate	No. of Beneficiaries Served	Availment Rate
1972	43,390	0.85	22,288	4.31	65,678	1.16
1973	174,392	2.71	137,336	6.68	311,728	3.67
1974	462,725	6.58	263,506	11.79	726,231	7.85
1975	550,798	6.82	347,011	11.80	897,809	8.16
1976	666,510	9.69	398,012	12.21	1,064,522	8.53
1977	689,753	6.83	445,069	12.90	1,134,822	8.35
1978	729,194	6.57	465,838	12.85	1,195,032	8.08
1979	797,717	6.55	506,380	12.94	1,304,097	8.12
1980	805,403	6.09	510,382	11.75	1,315,785	7.46
1981	830,651	5.93	508,024	11.55	1,338,675	7.23
1982	878,297	5.93	550,237	11.65	1,428,534	7.27
1983	925,700	5.70	615,292	12.32	1,540,992	7.22
1984	861,238	4.08	580,541	8.91	1,441,779	5.25
1985	885,146	4.10	571,190	7.64	1,456,336	4.99
1986	892,031	3.95	618,152	8.61	1,510,183	4.87
1987	896,968	5.92	658,735	12.85	1,555,703	7.10
1988	781,552	5.03	579,441	3.64	1,360,993	6.12
1989	689,150	4.34	615,328	9.38	1,304,478	5.79
1990	687,282	4.10	542,796	8.07	1,230,078	5.24
Average		5.36		10.36		6.45

*People who availed of services and received reimbursement ** (Beneficiaries Served/Coverage) x 100

Source: Philippine Medical Care Commission

Table 7 Premium Contribution Structure (Based on Executive Order No. 365)

Salary Bracket ₱	Contribution Base ₱	Employee's Share ₱	Employer's Share ₱
< 149	125	1.55	1.55
150 - 199.99	175	2.20	2.20
200 - 249.99	175	2.80	2.80
250 - 349.99	300	3.75	3.75
350 - 499.99	425	5.35	5.35
500 - 699.99	600	7.50	7.50
700 - 899.99	800	10.00	10.00
900 - 1,099.99	1,000	12.50	12.50
1,100 - 1,399.99	1,250	15.65	15.65
1,400 - 1,749.99	1,500	18.75	18.75
1,750 - 2,249.99	2,000	25.00	25.00
2,250 - 2,749.99	2,500	31.25	31.25
2,750 - above	3,000	37.50	37.50

Source: Philippine Medical Care Commission

In Figure 2, we see that, except for four years in the 1970s and most recently in 1990, collection income has outpaced benefit payments in nominal terms throughout a large part of the program's existence. This trend makes Medicare a financially sound program. Figure 3, on the other hand, reveals a much lower rate of change or even a decline in real values, when inflation is considered.

Benefit payments followed a similar trend. Figure 4 shows that the 40% increase in benefit payments observed earlier translates into a mere 10% increase in real terms, using the Consumer Price Index (CPI) as deflator. This implies that a large portion of the increase in current values came from changing prices and not increased availment rates. Using the Implicit Price Index (IPI) for medical services as deflator, the fall in real benefit payments was generally much greater (Figure 5), registering an annual average rate of change of -1.4%.

Differing trends in collection and benefit payments can be observed between SSS and GSIS. Table 9 (page 18) shows that between 1972 and 1990 the SSS collections grew annually at an average rate of 16.5% compared to 13.5% for the GSIS. The rate of change in collection income during the past five years was much higher than previously. For benefit payments, the reverse is true. They grew nearly twice as fast before 1986 than recently. This observation, when related to the increasing average value paid per claim since 1986, could signify that Medicare has been making headway in its efforts to curb abuse.

Between 1972 and 1992, benefit payments rose faster than collection income, at an annual average rate of change of 42% for SSS and 39% for GSIS. Higher average value paid per claim to SSS members explains why SSS has had a higher growth rate, despite lower utilization rates, than GSIS. The average value paid per claim shot up after 1985, after undergoing hardly any change in 1972-85, especially for the GSIS. The rate of increase for GSIS (20%) was, however, less than that for SSS (31%).

Table 8 Trends in Collection, Benefit Payments, and Average Value Paid Per Claim Total Medicare Program

Year	Collection (Million Pesos)	% Change	Benefit Payments (Million Pesos)	% Change	Ave. Value Paid Per Claim (Pesos)	% Change
1972	100.67		12.82		232.09	
1973	140.37	39.44	50.96	297.50	233.33	0.53
1974	164.40	17.12	175.81	245.00	230.94	-1.02
1975	185.29	12.71	198.48	12.89	230.79	-0.06
1976	212.38	14.62	246.82	24.36	241.70	4.73
1977	225.77	6.30	225.11	-8.80	217.68	-9.94
1978	251.28	11.30	263.93	17.24	223.19	2.53
1979	402.88	60.33	314.65	19.22	260.22	16.59
1980	446.72	10.88	318.65	1.27	262.62	0.92
1981	494.66	10.73	339.73	6.62	276.70	5.36
1982	520.83	5.29	379.73	11.77	274.33	-0.86
1983	553.20	6.22	400.30	5.42	273.98	-0.13
1984	576.30	4.18	414.40	3.52	294.63	7.54
1985	514.30	-10.76	439.10	5.96	307.46	4.35
1986	525.90	2.26	451.20	2.76	330.81	7.59
1987	824.30	56.74	574.80	27.39	426.27	28.86
1988	861.53	4.52	714.35	24.28	481.50	12.96
1989	1,056.85	22.67	726.07	1.64	588.36	22.19
1990	1,126.84	6.62	1,152.32	58.71	939.99	59.76
Average	1972-90	14.80	39.83	8.52		
	1972-85	1.26	45.86	2.81		
	1986-90	18.56	22.95	26.27		

Source: Philippine Medical Care Commission

Fig. 2 Current Coll. vs. Benefit Payment Overall Medicare

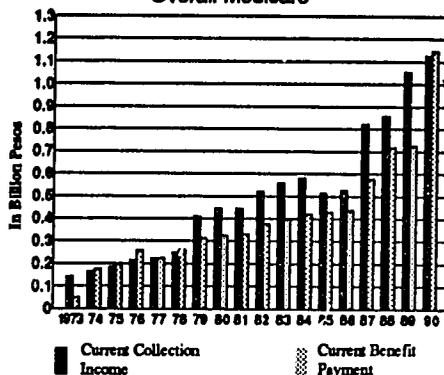


Fig. 3 Real vs. Nominal Collections Overall Medicare Program

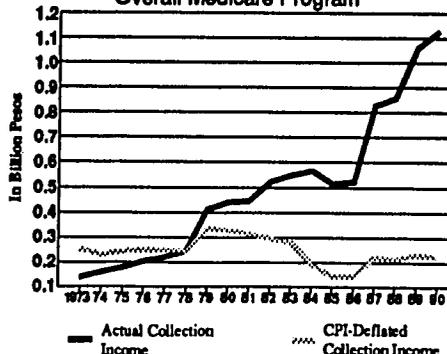


Fig. 4 Real vs. Nominal Benefit Payment Overall Medicare (CPI-Deflator)

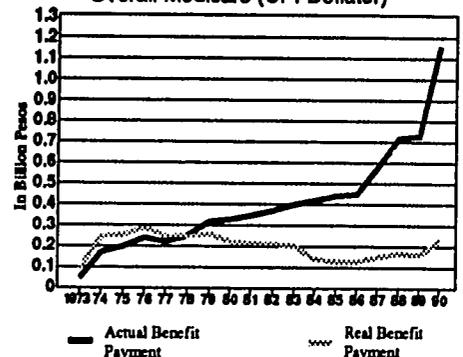


Fig. 5 Real vs. Nominal Benefit Payment Overall Medicare

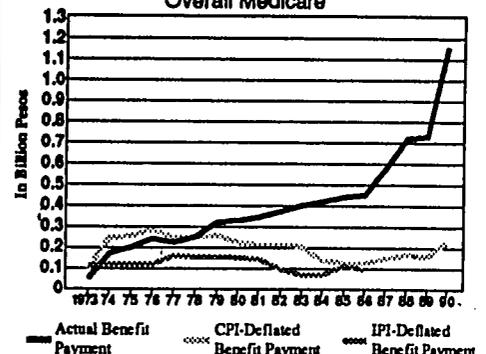


Table 9 Trends in Collections, Benefit Payments, and Average Value Paid per Claim (SSS and GSIS)

Year	Collection (Million Pesos)		% Change		Benefit Payments (Million Pesos)		% Change		Ave. Value Paid/Claim (Pesos)		% Change	
	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS
1972	56.71	43.96			7.70	5.12			228.78	327.25		
1973	100.63	39.74	77.45	-9.60	26.73	24.23	247.14	373.24	223.99	244.58	-2.09	-25.26
1974	106.50	57.90	5.83	45.70	119.86	55.95	348.41	130.91	236.02	220.77	5.37	-9.74
1975	122.03	63.26	14.58	9.26	126.49	71.99	5.53	28.67	241.00	214.82	2.11	-2.70
1976	140.66	71.72	15.27	13.37	161.70	85.12	27.84	18.24	242.46	240.26	0.61	11.84
1977	155.38	70.39	10.46	-1.85	137.57	87.54	-14.92	2.84	221.87	211.40	-8.49	-12.01
1978	173.74	77.54	11.82	10.16	178.16	85.74	29.50	-2.06	227.48	214.78	2.53	1.60
1979	264.67	138.21	52.34	78.24	208.53	106.12	17.05	23.77	263.88	253.32	16.00	17.94
1980	290.55	156.17	9.78	12.99	203.83	114.82	-2.25	8.20	272.40	246.89	3.23	-2.54
1981	313.75	180.94	7.99	15.86	214.68	125.05	5.32	8.91	281.65	268.59	3.40	8.79
1982	330.78	190.05	5.43	5.03	251.50	128.23	17.15	2.54	280.89	262.32	-0.27	-2.33
1983	340.60	212.60	2.97	11.87	259.10	141.20	3.02	10.11	283.72	257.75	1.01	-1.74
1984	342.40	233.90	0.53	10.02	241.20	173.20	-6.91	22.66	294.61	294.66	3.84	14.32
1985	332.80	181.50	-2.80	-22.40	265.10	174.00	9.91	0.46	304.89	311.46	3.49	5.70
1986	335.20	190.70	0.72	5.07	280.30	170.90	5.73	-1.78	338.20	319.35	10.93	2.53
1987	546.20	278.10	62.95	45.83	350.20	224.60	24.94	31.42	459.10	383.51	35.75	20.09
1988	616.05	245.48	12.79	-11.73	475.03	239.32	35.65	6.55	533.37	403.59	16.18	5.24
1989	731.13	325.72	18.68	32.69	449.52	276.55	-5.37	15.56	626.19	535.75	17.40	32.75
1990	777.44	349.40	6.33	7.27	710.50	441.82	58.06	59.76	1,092.47	767.69	74.46	43.29
Average	1972-90		16.48	13.57			42.41	38.95			9.76	5.67
	1972-85		15.12	12.76			49.06	44.89			2.19	0.28
	1986-90		20.29	15.83			23.80	22.30			30.94	20.78

Source: Philippine Medical Care Commission

FINANCIAL PERFORMANCE

The HIF consists of contributions from members, earnings from investments, and other incomes such as penalties imposed on employers for not remitting contributions on time.

Table 10 on page 19 shows the changing composition of income for the two systems and for Medicare as a whole. Collection income as a percentage of total income has been steadily declining. The decline has been more pronounced for SSS, which now depends on investment income rather than collections. In 1990, investment income accounted for 52% of its total income, and collections, for 48%. Despite an improved investment performance, GSIS, on the other hand, still relies heavily on its members' contributions, which composed 71% of its total income in 1990.

Since both systems invest their HIFs in

government securities, their investment performance should not be much different. The disparity could be due to the fact that GSIS investments before 1986 were locked in unproductive assets.

The growing independence of the HIF from premium contributions makes it better able to withstand inflationary pressures from diminishing real contributions and enhances the risk-sharing ability of Medicare. The increasing share of investment income in the combined HIF, from 1.5% in 1972 to 47% in 1990, also means that the fund administrators have been managing investments more skillfully.

Table 11 (page 19) indicates that Medicare, as a whole, registered positive net insurance gain (collection income less total expenses) between 1979 and 1989. Total collections alone—excluding investment and other income—were more than enough to cover Medicare expenses. But a sharp rise in benefit payments produced a negative net insurance gain in 1990.

From Table 12 (page 20), we can see that SSS has had consistently positive net insurance gains since 1979, while GSIS had a negative net insurance gain in 1990. Since 1980, SSS' annual net income (total income less total expenses) has been more than ₱100 million, with the highest recorded at ₱845 million in 1990. On the other hand, GSIS' net income exceeded ₱100 million only twice between 1980 and 1990.

The extent to which the two systems can underwrite benefit payments and other expenses depends largely on their reserves. The last two columns of Tables 11 and 12 show how these reserves have grown. At the end of 1990, Medicare had ₱5.2 billion in reserves. Total reserves have been rising steadily through the years and for SSS the growth has been substantial, reaching the billion mark in 1984 and about ₱4.5 billion in 1990. GSIS' reserves amounted to only ₱620 million in 1990.

Reserve capacity, or reserve levels as a percentage of total expenses, can be

Table 10 Composition of Income

Year	% of Total Income								
	SSS			GSIS			Total Medicare		
	Collection	Investment Income	Other Income	Collection	Investment Income	Other Income	Collection	Investment Income	Other Income
1972	98.00	2.00	0.00	99.00	1.00	0.00	98.50	1.50	0.00
1973	93.30	6.70	0.00	96.20	3.80	0.00	94.10	5.90	0.00
1974	89.90	10.10	0.00	96.20	3.80	0.00	92.00	8.00	0.00
1975	90.50	9.50	0.00	92.40	7.60	0.00	92.00	8.80	0.00
1976	91.10	8.90	0.00	94.20	5.80	0.00	92.10	7.90	0.00
1977	91.30	8.70	0.00	96.30	3.10	0.60	92.80	7.00	0.20
1978	91.10	8.90	0.00	97.80	2.10	0.10	93.10	6.90	0.00
1979	91.80	7.90	0.30	97.70	1.20	1.20	93.70	5.70	0.60
1980	88.10	11.60	0.30	96.90	2.50	0.60	91.00	8.60	0.40
1981	83.70	16.10	0.20	96.80	3.20	0.00	88.00	11.80	0.10
1982	79.40	21.20	0.40	90.00	10.00	0.00	83.00	16.70	0.30
1983	75.30	24.20	0.50	89.10	10.90	0.00	80.10	19.60	0.30
1984	64.40	35.30	0.30	88.30	11.70	0.00	72.30	27.50	0.20
1985	47.60	52.20	0.20	90.30	9.70	0.00	57.10	42.70	0.20
1986	48.40	51.40	0.20	89.40	10.60	0.00	58.10	41.80	0.10
1987	62.00	37.90	0.10	98.50	1.50	0.00	70.80	29.10	0.10
1988	60.20	39.80	0.10	81.10	18.90	0.00	64.90	35.00	0.10
1989	56.80	43.20	0.00	78.40	21.60	0.00	62.00	38.00	0.00
1990	48.10	51.90	0.00	70.80	29.20	0.00	53.50	46.50	0.00

Source: Philippine Medical Care Commission

Table 11 Financial Performance, Total Medicare (SSS and GSIS) (in Million Pesos)

Year	Total Medicare Income				Total Medicare Expenses			Net Insurance Gain	Net Income	Cumulative Reserves	
	Collection Income	Investment Income	Other Income	Total	Benefit Payments	Operating Expenses	Total Expenses			Reserves	Capacity
1972	100.67	1.57	0.00	102.24	12.82	1.13	13.95	86.72	88.29	88.10	6.32
1973	140.37	8.86	0.00	149.23	50.96	5.76	56.72	83.65	92.51	176.56	3.11
1974	164.40	14.23	0.00	178.63	175.81	8.13	183.94	-19.54	-5.31	164.43	0.89
1975	185.29	17.96	0.00	203.25	198.48	9.46	207.94	-22.65	-4.69	149.50	0.72
1976	212.38	18.13	0.02	230.53	246.82	9.41	256.23	-43.85	-25.70	118.46	0.46
1977	225.77	17.06	0.43	243.26	225.11	9.22	234.33	-8.56	8.93	116.64	0.50
1978	251.28	18.64	0.05	269.97	263.93	9.27	273.20	-21.92	-3.23	105.10	0.38
1979	402.88	24.48	2.56	429.92	314.65	12.48	327.13	75.75	102.79	182.28	0.56
1980	446.72	42.28	2.05	491.05	318.65	18.82	337.47	109.25	153.58	298.38	0.88
1981	494.66	66.45	0.72	561.83	339.73	26.40	366.13	128.53	195.70	443.04	1.21
1982	520.83	104.97	1.61	627.41	279.73	12.12	291.85	228.98	335.56	557.02	1.91
1983	553.20	135.50	2.15	690.85	400.30	14.60	414.90	138.30	275.95	709.94	1.71
1984	576.30	218.90	1.52	796.72	414.40	19.50	433.90	142.40	362.82	1,379.70	3.18
1985	514.30	384.60	1.38	900.28	439.10	22.50	461.60	52.70	438.68	1,852.80	4.01
1986	525.90	378.35	1.30	905.55	451.20	34.60	485.80	40.10	419.75	2,271.20	4.68
1987	824.30	338.70	0.81	1,163.81	574.80	39.90	614.70	209.60	549.11	2,819.50	4.59
1988	861.53	464.51	0.70	1,326.74	714.35	48.40	762.75	98.78	563.99	3,378.87	4.43
1989	1,056.85	646.62	0.00	1,703.47	726.07	51.73	777.80	279.05	925.67	4,303.71	5.53
1990	1,137.42	987.09	0.00	2,124.51	1,152.32	68.68	1,221.00	-83.58	903.51	5,205.45	4.26
Average										2.60	

Net Insurance Gain = Collection Income Less Total Expenses

Net Income = Total Income Less Total Expenses

Reserve Capacity = Cumulative Reserves/Total Expenses

Source: Philippine Medical Care Commission

Table 12 Financial Performance, SSS and GSIS (In Million Pesos)

Year	Income								Expenses						Net Insurance Gain		Net Income		Cumulative Reserves (million)		Reserves Capacity (Years)			
	Collection		Investment Income		Other Income		Total Income		Benefit Payments		Operating Expenses		Total Expenses		SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS
	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS										
1972	56.71	43.96	1.13	0.44			57.84	44.40	7.70	5.12	0.41	0.72	8.11	5.84	48.60	38.12	49.73	38.56	49.27	38.83	6.08	6.65		
1973	100.63	39.74	7.27	1.59			107.90	41.33	26.73	24.23	1.46	4.30	28.19	28.53	72.44	11.21	79.71	12.80	122.23	54.33	4.34	1.90		
1974	106.50	57.90	11.93	2.30			118.43	60.20	119.86	55.95	2.99	5.14	122.85	61.09	-16.35	-3.19	-4.42	-0.89	108.23	56.27	0.88	0.92		
1975	122.03	63.26	12.76	5.20			134.79	68.46	126.49	71.99	3.03	6.43	129.52	78.42	-7.49	-15.16	5.27	-9.96	101.96	47.54	0.79	0.61		
1976	140.66	71.72	13.75	4.38		0.02	154.41	76.12	161.70	85.12	3.79	5.62	165.49	90.74	-24.83	-19.02	-11.08	-14.62	84.32	34.14	0.51	0.38		
1977	155.38	70.39	14.77	2.29		0.43	170.15	73.11	137.57	87.54	4.43	4.79	142.00	92.33	13.38	-21.94	28.15	-19.22	99.83	16.81	0.70	0.18		
1978	173.74	77.54	16.94	1.70		0.05	190.68	79.29	178.19	85.74	3.29	6.03	181.48	91.77	-7.74	-14.23	9.20	-12.48	98.07	7.03	0.54	0.08		
1979	264.67	138.21	22.85	1.63	0.91	1.65	288.43	141.49	208.53	106.12	3.59	8.89	212.12	115.01	52.55	23.20	76.31	26.48	153.61	28.67	0.72	0.25		
1980	290.55	156.17	38.22	4.00	1.05	1.00	329.82	161.17	203.83	114.82	3.82	15.00	207.65	129.82	82.90	26.35	122.17	31.35	241.88	56.50	1.16	0.44		
1981	313.72	180.94	60.45	6.00	0.72		374.89	186.94	214.68	125.05	7.06	19.34	221.74	144.39	91.98	36.55	153.15	42.55	341.17	101.87	1.54	0.71		
1982	330.78	190.05	83.97	21.00	1.61		416.36	211.05	251.50	28.23	7.12	5.00	258.62	33.23	72.16	156.82	157.74	177.82	421.32	135.70	1.63	4.08		
1983	340.60	212.60	109.40	26.10	2.15		452.15	238.70	259.10	141.20	7.30	7.30	266.40	148.50	74.20	64.10	185.75	90.20	502.8	207.14	1.89	1.39		
1984	342.40	233.90	188.00	30.90	1.52		531.92	264.80	241.20	173.20	8.90	10.60	250.10	183.80	92.30	50.10	281.82	81.00	1,136.9	242.80	4.55	1.32		
1985	332.80	181.50	365.10	19.50	1.38		699.28	201.00	265.10	174.00	9.10	13.40	274.20	187.40	58.60	-5.90	425.08	13.60	1,560.6	292.20	5.69	1.56		
1986	335.20	190.70	355.75	22.60	1.30		692.25	213.30	280.30	170.90	27.30	7.30	307.60	178.20	27.60	12.50	384.65	35.10	1,943.9	327.30	6.32	1.84		
1987	546.20	278.10	334.50	4.20	0.81		881.51	282.30	350.20	224.60	33.2	6.70	383.40	231.30	162.80	46.80	498.11	51.00	2,441.2	378.30	6.37	1.64		
1988	616.05	245.48	407.29	57.22	0.7		1,024.04	302.70	475.03	239.32	41.9	6.50	516.93	245.82	99.12	-0.34	507.11	56.88	2,943.87	435.00	5.69	1.77		
1989	731.13	325.72	556.98	89.64			1,288.11	415.36	449.52	276.55	44.41	7.32	493.93	283.87	237.20	41.85	794.18	131.49	3,737.04	566.28	7.57	1.99		
1990	777.44	359.98	838.61	148.48			1,616.05	508.46	710.50	441.82	60.22	8.46	770.72	450.28	6.72	-90.30	845.33	58.18	4,583.15	620.31	5.95	1.38		

Source: Philippine Medical Care Commission

interpreted as the number of years current reserves can cover disbursements or expenses. The annual reserve capacity of the two systems combined is approximately two years—a level that is generally considered safe by actuaries—and, in Medicare's best ever performance in nearly 20 years of existence, has averaged about four years in the last five years. On the average, SSS' reserve capacity is stronger, at six years, compared to the GSIS' 1.7 average. Both systems had a start-up reserve capacity of six years, but the SSS recovered faster from a reserve slump in the 1970s, with spectacular increases in capacity since 1984, while GSIS has not yet reached a reserve capacity of two years.

This contrasting financial performance inhibits the Medicare program from improving benefits. SSS' higher average values paid per claim compared to GSIS' have created a dual system of medical care. The extent to which economies of scale can be achieved with the integration of the two HIFs deserves serious consideration. Integration may, however, require legislation and political consensus. Moreover, SSS members may not take kindly to a perceived dilution of their fund.

FUND UTILIZATION

Tables 13 to 15 (pages 22 to 23), show how much of premium income went to benefits and operating expenses. The tables also show some analysis per beneficiary.

Benefit payments, which were shown earlier to be rising at current prices, have been the single biggest expense for the HIF. For the whole program, benefit payments (P1,152 million) surpassed premium collections (P1,137 million) in 1990. The value of benefits per beneficiary increased by 68% in 1990, compared with a 6% increase in 1989. This increase indicates that the fewer availments made in 1990, as discussed, carried higher payment values. Per capita, the values have been rising more slowly.

The share of operating expenses in

premium income has kept within the 12% limit set by the Medicare law. Per beneficiary, they have been increasing yearly at an average rate of 11%. Operating cost per capita is relatively low; in 1990 it was about P2.93. But, given the propensity for abuse of Medicare benefits, low operating cost per capita is not necessarily a positive sign since cases of abuse may remain undetected.

Tables 14 and 15 show that SSS has consistently paid more benefits than GSIS since the start of Medicare in 1972, although GSIS benefits as a percentage of collection income were nearly twice SSS'. Since premiums make up the bulk of GSIS' income (71% in 1990), GSIS effectively depends on its premium collections to fund its benefit payments.

Per beneficiary, GSIS beneficiaries received higher benefits in 1990 (P814) than their counterparts in SSS (P654). In some other years, the reverse was true. A study of these variations in per beneficiary payments would reveal the illnesses, hospital preferences (primary, secondary, or tertiary), and types of medical expenses of Medicare beneficiaries.

Particularly in recent years, the two systems have differed widely in their Medicare operating expenses. In 1990, SSS spent about P60 million while GSIS spent P8.5 million. The sharp increase in SSS' operating expenses since 1986 may be explained by its greater vigor in fraud monitoring, its computerization program, and the decentralization to the regions. The average rate of change in SSS' operating expenses per beneficiary (19%) has been double that of the average rate of change in its payments per beneficiary (9%). For GSIS, it was just the opposite, with the change in per beneficiary payments averaging 8.7% versus a 4.2% average change in operating expenses per beneficiary. It is worth finding out whether more funds for the monitoring of abuse do indeed produce greater efficiency by cutting down on unnecessary availments and limiting reimbursements to more serious and also more expensive cases.

The difference in fund utilization

between the two systems raises the crucial question of operating efficiency. As noted earlier, it does not help to keep operating expenses low (as for GSIS) if the system cannot curb abuse and if it takes as long as five or six months to process reimbursement claims. On the other hand, SSS' higher and increasing operating expense per beneficiary suggests that the Medicare program is becoming increasingly more complex despite the fact that it covers a supposedly more manageable group, the organized sector. Thus, implementing Program II—for the unorganized and unemployed—poses an even greater administrative challenge.

SUPPORT VALUE

The support value (the portion of total hospitalization costs supported by Medicare) is a policy issue. The original intent was for Medicare to cover at least 70% of the actual costs of confinement in a private hospital ward. But while the actual costs have been rising through the years, Medicare has made only incremental changes in benefit allowances, leading to a much-reduced support value.

Table 16 shows overall support values, even at their highest level (in 1989), falling short of the targeted 70%. Support is much higher for confinement in a government, versus a private, hospital, particularly at the primary level where a support value of 91% was achieved in 1989. A PMCC survey that year revealed a predominance of private-hospital confinements (76%).

Generally, among the three hospital types, support value has been highest at the primary level, followed by secondary, then tertiary. By providing for higher reimbursable allowances, the benefit structure itself encourages the use of higher-level facilities. For as long as the quality and pricing of hospital services vary, a consumer bias for higher-level facilities can be expected.

The support value data were estimated from a nationwide survey done regularly by the PMCC. The most recent one, in 1990, revealed that nearly half of the

Table 13 Fund Utilization, Total Medicare (SSS and GSIS)

Year	Benefits Paid					Operating Expenses				
	Amount (Million Pesos)	% of Collection Income	Per Beneficiary (Pesos)	% Change per Beneficiary	Per Capita (Pesos)	Amount (Million Pesos)	% of Collection Income	Per Beneficiary (Pesos)	% Change per Beneficiary	Per Capita (Pesos)
1972	12.82	12.7	195.19		2.29	1.13	1.1	17.21		0.20
1973	50.96	36.3	163.48	-16.2	6.02	5.76	4.1	18.48	7.4	0.68
1974	175.81	106.9	242.09	48.1	19.01	8.13	4.9	11.19	-39.4	0.88
1975	198.48	107.1	221.07	-8.7	18.06	9.46	5.1	10.54	-5.9	0.86
1976	246.82	116.2	198.37	4.9	19.87	9.41	4.4	8.84	-16.1	0.76
1977	225.11	99.7	220.86	-14.4	16.63	9.22	4.1	8.12	-8.1	0.68
1978	263.93	105.0	240.89	11.3	17.93	9.27	3.7	7.76	-4.5	0.63
1979	314.15	78.0	242.17	9.1	19.62	12.48	3.1	9.57	23.4	0.78
1980	318.65	71.3	253.78	0.5	18.15	18.82	4.2	14.30	49.5	1.07
1981	339.73	68.7	265.82	4.8	18.46	26.40	5.3	19.72	37.9	1.43
1982	379.73	72.9	259.77	4.7	19.44	12.12	2.3	8.48	-57.0	0.62
1983	400.30	72.4	287.42	-2.3	18.78	14.60	2.6	9.47	11.7	0.68
1984	414.40	71.9	301.51	10.6	15.00	19.50	3.4	13.52	42.8	0.71
1985	439.10	85.4	298.77	4.9	15.11	22.50	4.4	15.45	14.2	0.77
1986	451.20	85.8	369.48	-0.9	15.16	34.60	6.6	22.91	48.3	1.16
1987	574.80	69.7	524.87	23.7	36.32	39.90	4.8	25.65	11.9	1.83
1988	714.35	82.9	556.60	42.1	32.13	48.40	5.6	35.56	38.7	2.18
1989	726.07	68.7	936.79	6.0	32.36	268.68	4.9	39.66	11.5	2.31
1990	1,152.32	101.3	987.09	68.3	49.10	1,152.32	6.0	55.83	40.8	2.93
Average				10.34					10.90	

Source: Philippine Medical Care Commission

Table 14 Fund Utilization, SSS

Year	Benefits Paid					Operating Expenses				
	Amount (Million Pesos)	% of Collection Income	Per Beneficiary (Pesos)	% Change per Beneficiary	Per Capita (Pesos)	Amount (Million Pesos)	% of Collection Income	Per Beneficiary (Pesos)	% Change per Beneficiary	Per Capita (Pesos)
1972	7.70	13.6	177.46		1.52	0.41	0.7	9.45		0.08
1973	26.73	26.6	153.28	-13.6	4.16	1.46	1.5	8.37	-11.4	0.23
1974	119.86	112.5	259.03	69.0	17.07	2.99	2.8	6.46	-22.8	0.43
1975	126.49	103.7	229.65	-11.3	15.71	3.03	2.5	5.50	-14.9	0.38
1976	161.70	115.0	242.61	5.6	17.65	3.79	2.7	5.69	3.4	0.41
1977	137.57	88.5	199.45	-17.8	13.63	4.43	2.9	6.42	12.9	0.44
1978	178.19	102.6	244.37	22.5	16.05	3.24	1.9	4.44	-30.8	0.29
1979	208.53	78.8	261.41	7.0	17.23	3.59	1.4	4.50	1.3	0.30
1980	203.83	70.2	253.08	-3.2	15.42	3.82	1.3	4.74	5.4	0.29
1981	214.68	68.4	258.45	2.1	15.33	7.06	2.3	8.50	79.2	0.50
1982	251.50	76.0	286.35	10.8	16.98	7.12	2.2	8.11	-4.6	0.48
1983	259.10	76.1	279.90	-2.3	15.87	7.30	2.1	7.89	-2.7	0.45
1984	241.20	70.4	280.06	0.1	11.42	8.90	2.6	10.33	31.0	0.42
1985	265.10	72.5	272.50	-2.7	11.17	9.10	2.7	10.28	-0.5	0.42
1986	280.30	79.1	297.19	9.1	11.74	27.30	8.1	30.60	197.7	1.21
1987	350.20	51.3	312.50	5.2	18.51	33.20	6.1	37.01	20.9	2.19
1988	475.03	56.8	448.08	43.4	22.55	41.90	6.8	53.61	44.8	2.70
1989	449.52	65.0	689.30	53.8	29.91	44.41	6.1	64.44	20.2	2.80
1990	710.50	57.8	654.05	-5.1	26.84	60.22	7.7	87.62	36	3.60
Average				9.08					19.22	

Source: Philippine Medical Care Commission

Table 15 Fund Utilization, GSIS

Year	Benefits Paid					Operating Expenses				
	Amount (million)	% of Collection Income	Per Beneficiary (P)	% Change per Beneficiary	Per Capita (P)	Amount (million)	% of Collection Income	Per Beneficiary (P)	% Change per Beneficiary	Per Capita (P)
1972	5.12	11.6	229.72		10.04	0.72	1.6	32.30		1.41
1973	24.23	61.0	176.43	-23.2	11.82	4.30	10.8	31.31	-3.1	2.10
1974	55.95	96.6	212.33	20.3	25.09	5.14	8.9	19.51	-37.7	2.30
1975	71.99	113.8	207.46	-2.3	24.49	6.43	10.2	18.53	-5.0	2.19
1976	85.12	118.7	213.86	3.1	26.11	5.62	7.8	14.12	-23.8	1.72
1977	87.54	124.4	196.69	-8.0	25.37	4.79	6.8	10.76	-23.8	1.39
1978	85.74	110.6	184.06	-6.4	23.69	6.03	7.8	12.94	20.3	1.67
1979	106.12	76.8	209.57	13.9	27.14	8.89	6.4	17.56	35.6	2.27
1980	114.82	73.5	224.97	7.3	26.46	15.00	9.6	29.39	67.4	3.46
1981	125.05	69.1	246.15	9.4	28.42	19.34	10.7	38.07	29.5	4.40
1982	128.23	67.5	233.05	-5.3	27.17	5.00	2.6	9.09	-76.1	1.06
1983	141.20	66.4	229.48	-1.5	28.30	7.30	3.4	11.86	30.6	1.46
1984	173.20	74.0	298.34	30.0	26.61	10.60	4.5	18.26	53.9	1.63
1985	174.00	95.9	304.63	2.1	23.29	13.40	7.4	23.46	28.5	1.79
1986	170.90	89.6	276.47	-9.2	23.80	7.30	3.8	11.81	-49.7	1.02
1987	224.60	80.8	340.96	23.3	33.52	6.70	2.4	10.17	-13.9	1.00
1988	239.32	97.5	413.02	21.1	35.72	6.50	2.6	11.22	10.3	0.97
1989	276.55	84.9	449.44	8.8	42.16	7.32	2.2	11.90	6.0	1.12
1990	441.82	122.7	813.97	81.1	65.75	8.46	2.4	15.59	31.0	1.26
Average				8.66					4.22	

Source: Philippine Medical Care Commission

Table 16 Support Values for the Medicare Program Selected Years, with Type of Hospital and Ownership

Year	Type of Hospital			Overall Support Rate (%)
	Primary	Secondary	Tertiary	
1981	48.4	33.8	23.6	39.8
1985	n.a.	n.a.	n.a.	31.5
1987	55.8	38.4	25.8	33.4
1989	66.2	46.1	45.8	48.9
Ownership Type (1989)				
Private	64.3	40.4	33.9	41.4
Gov't	91.3	86.9	32.9	84.7
Overall	66.2	46.1	45.8	48.9

n.a. = not available

Source: Philippine Medical Care Commission

hospitalization cases reported for 1989 were for acute gastroenteritis and bronchitis.

Table 17 on page 24 shows the average actual cost incurred by patients and the Medicare support value for each type of hospital service. As expected, confinement is generally more costly in private hospitals

than in government hospitals. Medicare support value is highest for drugs and medicines and related expenses, and lowest for professional fees. (Given the customary reluctance of professionals to divulge their fees, the fee figures given in Table 17 may be grossly understated, thereby bloating the support values.)

Table 17 also ranks the various items of hospitalization cost according to their Medicare support value and actual cost. Drugs and medicines take up the largest share of expenses in both government and private hospitals, yet in terms of Medicare support value they rank next to the lowest in government hospitals. (In private hospitals, on the other hand, they get the most Medicare support.) Overall, there are other incongruencies. The second most expensive item, room and board, ranks only fifth in Medicare support value. Operating room fees, number three in Medicare support value, are the lowest in actual cost. This comparative ranking suggests that Medicare should improve its support for room and board, diagnostic services, and operating room fees.

Table 17 also shows that hospital confinements usually last longer in government hospitals (5 days on the average) than in private hospitals (3.4 days), although private-hospital patients claim about 50% more (P2,100 per claim) than those confined in government hospitals (P1,383). Research on these disparities in length and cost of hospital confinement could yield useful insights into provider behavior and pricing policy and help draw up a profile of beneficiaries.

MEDICARE'S CURRENT AND POTENTIAL ROLE IN PHILIPPINE HEALTH CARE

This section looks into the capacity of the Medicare program to respond to certain basic issues, which have been brought out in the foregoing analyses. The impact of Medicare on the health sector will also be assessed.

ASSESSMENT OF THE MEDICARE SYSTEM

The Medicare program will be analyzed in terms of its organizational responsiveness, financial and operating efficiency, and regulatory influence. In the process, functional relationships among the various institutions in the health-care financing sector will also be discussed.

Organizational Responsiveness

The relationships between and among implementing agencies and between the PMCC and the providers, the overall responsiveness of Medicare to the needs of members and providers, and the use of Medicare resources by providers are all matters of policy interest.

The fragmentation of responsibility for Medicare policy making and operation among three different, independent government agencies keeps Medicare from

taking full advantage of economies of scale and operating more efficiently. For instance:

- The SSS is now decentralizing its claims processing system, yet the GSIS—which takes up to five months to process provider claims—is still centralized. While the two systems have raised no objections to joint decentralized processing, which has been discussed in PMCC board meetings, no concrete step as yet has been taken to carry it out.
- Efforts to coordinate the activities and schedules of the SSS, GSIS, and PMCC inspection teams monitoring service providers have not led to the desired efficiency and have instead aroused discontent in the team that is the poorest compensated among the three.
- The two systems follow different accounting policies and financial reporting standards, making it difficult to consolidate reports and get a total picture of the Medicare program.

- The present structure is not conducive to uniformity in investment policies and does not provide for uniform performance standards for premium collection and claims processing.

As social insurance institutions, the two systems are basically oriented towards the wage-based sector, a limitation that they should outgrow if they are to play key administrative roles in the implementation of Program II. Moreover, it would be interesting to find out whether the added responsibility of managing other social insurance programs (such as pension plans and the ECC) impedes the SSS and GSIS from providing health services in innovative ways.

The PMCC does not have line authority over the two systems. The segmentation of functions among three different organizations has its strengths and weaknesses. However, the possibility of placing the whole Medicare program under a single institution, which retains the positive

Table 17 Average Actual Costs, Medicare Support Value, and Rank Differences, 1989

Hospitalization Item	Average Actual Costs Incurred			Medicare Support Value			Rank in Actual Medicare Support Value					
	Gov't Hospital	Private Hospital	Combined Average	Gov't Hospital	Private Hospital	Overall	Gov't Hospital		Private Hospital		Combined	
	(Pesos)	(Pesos)	(Pesos)	(%)	(%)	(%)	Actual Value	Support Value	Actual Value	Support Value	Actual Value	Support Value
Room and Board per Day	50.58	107.62	89.40	91.8	37.8	47.6	3	1	2	5	2	5
Medical Expense Benefits	519.73	896.12	806.02	75.8	47.3	51.7						
Drugs and Medicines	345.38	628.57	560.78	79.1	49.8	54.1	1	6	1	1	1	1
Lab, X-ray, etc.	218.02	319.47	296.03	69.1	41.6	46.2	4	7	4	2	4	7
Professional Fees	171.96	292.13	66.17	83.2	41.1	47.7	5	5	5	3	5	6
Operating Room Fees							7	2	6	4	6	3
RUV 5 and below	228.22	670.58	502.65	89.9	29.0	39.5						
RUV 5.1 - 10	371.38	1,183.37	881.77	96.5	29.8	40.2						
RUV 10.1 and above	731.57	1,635.79	1,348.09	100.0	47.5	56.6						
Surgeon's Fees							2	3	3	6	3	2
RUV 5 and below	643.08	2,106.94	1,477.93	90.3	29.0	40.4						
RUV 5.1 - 10	1,916.91	4,106.77	3,196.38	100.0	37.1	52.7						
RUV 10.1 and above	2,883.81	6,267.98	5,033.21	95.1	43.1	54.0						
Anesthesiologist's Fees							6	4	7	7	7	4
RUV 5 and below	238.81	1,045.33	649.98	87.8	23.1	34.7						
RUV 5.1 - 10	606.87	1,673.53	1,160.45	98.4	31.6	48.3						
RUV 10.1 and above	875.15	2,007.64	1,552.37	92.9	41.7	53.3						
Other Fees	205.74	272.90	263.09									
Total Amount per Claim	1,383.29	2,100.95	1,931.52	84.7	41.4	48.9						
Ave. No. of Days' Confinement	5.02	3.39	3.78									
% of Claims	24.0	76.0	100.0									

Source: Philippine Medical Care Commission

administrative features of the present system, can be studied and considered. SSS and GSIS may continue to collect premium contributions for a fee, while the designated institution, which can be any one of the three or an entirely new body, can take care of policy making, fund management, and claims processing.

The limited organizational capacities of the three agencies foster a system that is ill-equipped technically and administratively to explore alternative benefit systems and improve the use of medical resources. For instance, the PMCC itself does not have an actuary (even on a consulting basis) and has to depend on the two systems for actuarial studies. The situation is worsened by the lack of regular and standardized financial, utilization, and cost data from the two systems.

Among the beneficiaries, low support values, lack of detailed knowledge about benefits and availment procedures, and slow claims processing dampen enthusiasm and interest in the program. While the extent to which low premiums contribute to this apparent apathy is still to be ascertained, it can be surmised that as an individual contributes progressively more to the program, his needs and interests will be better attended to. A study done by the Philippine Hospital Association in 1980 and cited by Alfiler (1986) disclosed that Medicare beneficiaries composed 54% of private-hospital and 60% of government-hospital admissions. This indicates the extent of beneficiary appreciation the program could generate if support values were to be increased, and points to the potential of the program for helping hospitals become financially viable.

Providers may look at the PMCC as more of a regulatory agency which accredits medical practitioners and hospitals as a precondition to their participation in the Medicare program. But physicians have ignored Medicare as a source of professional fees, particularly when it comes to the care of patients confined in private hospital rooms. The previous analyses show that the program can be a revenue source, especially for primary hospitals where the support value is high. In its first years, Medicare was found to have an impact on

the growth of hospital capacity, especially in underserved areas (Akin 1984). This phenomenon widened access to facilities but also spawned abuses.

Financial Efficiency

Financial efficiency is defined as the ability to manage the HIF so that it can absorb benefit payments and other expenses. It is an indicator of the stability or solvency of the program, and its responsiveness to the benefit needs of members.

The previous analyses show that as of 1990, the systems had a combined reserve of about four years. Some quarters advocate the consolidation of the two HIFs to resolve the perennial problem of having to defer an increase in benefits for SSS members until the GSIS HIF reaches a level high enough to warrant a similar increase for GSIS members. The integration of the HIFs will require legislation and consensus building among SSS members.

A policy question may be raised, though, regarding the appropriate level of reserves for a program that is funded largely by contributions from its members, who expect to obtain a given set of benefits in return. Accumulating reserves at the expense of higher benefit packages and greater affordability of health care may not be to the members' interest. In an economic analysis by Lague (1988), SSS was seen to tend towards stability of reserves and GSIS to be more oriented to benefit responsiveness if not for its weak, though improving, finances. It is important, however, to remember that attempts to increase benefit levels by providing additional funding (through higher premiums, lower reserve levels, or other means) must be accompanied with strong measures to thwart abuse and keep health costs from escalating. In other words, benefit increases must be considered not only in relation to beneficiaries and providers but also in relation to the health sector as a whole.

Operating Efficiency

Operating efficiency refers to the degree to which benefit payments reflect the actual services rendered. The PMCC has a priority list of high-risk hospitals and

has instituted a regular system of hospital monitoring, which calls for scrutiny of the clinical monthly reports of operations of hospitals and a comparison of current with previously reported levels. In just three provinces monitored over a two-month period, estimates of savings that could have been realized from more accurate reporting were placed at about ₱1.15 million.

Other operating concerns are slow claims processing and inadequate information systems. As has been mentioned, the GSIS takes up to five or six months to process a claim, while the SSS takes only 30 days. This delayed processing of claims is a financial disincentive to service providers, given the high interest rates.

The need for an adequate information base for sound decision making at PMCC prompted an Andersen Consulting study on PMCC's information needs (Andersen Consulting 1990). The study looked into the regulatory and implementing functions of the PMCC and noted the general lack of a data base. Should Medicare be expanded, as Medicare Program II or an enhanced version of the current program, an information system must be set in place to keep track of utilization, provider and beneficiary profiles, and geographic variances, among others.

Regulatory Influences in Health-Care Financing

Health insurance as a mode of financing and providing health-care services has its roots in the Constitution, and is given impetus in the government's Medium-Term Development Plan and made concrete in the Medicare law.

Yet, while the law envisions a strong role for the government in health-service delivery and financing, the Constitution also calls upon the state to recognize and encourage private enterprise, as a matter of policy. According to Intercare (1987), private health-care expenditures account for 75% of health-care expenditures in the country. The Medicare law, recognizing this formidable private-sector presence, provides for the use of private health facilities.

The players in health-service delivery and financing in the country are regulated by various government instrumentalities. Health facilities need a license from the DOH to operate. The Professional Regulation Commission (PRC) has legal authority over health practitioners like doctors and dentists. The Insurance Commission regulates the operations of commercial insurance companies.

The Medicare law does not vest any such regulatory powers in the PMCC, except for the accreditation of service providers participating in the Medicare program itself. Therefore, until it is given the necessary legal authority, the PMCC cannot regulate the HMOs as has been suggested. And even with such a mandate, the PMCC still needs to develop the necessary manpower and systems.

The present organization (shown in Annex A) and staffing of the PMCC show a preponderance of administrative personnel rather than technical people. Overall program directions are determined by the PMCC board, headed by a chairman. The board is assisted by various executive committees which largely carry out legal tasks—hearing and investigation, claims appeals, accreditation, and rules and regulations. About 300 regional and provincial medical officers handle clerical and monitoring functions. Of the four services of the PMCC, two are regulatory: hearing and investigation, and accreditation services. A third service, programs development, plans and does research on the development of new Medicare programs and monitors overall program performance.

PMCC's staff lacks critical research and planning capacity. There is no resident actuary or consultant; actuarial services have to be sourced from the two systems. Given current budgetary constraints and the government's low incentives, the PMCC may find it difficult to bolster its technical staff. Even if it is allowed to hire technical people from outside, it will still have to upgrade the current technical and administrative skills and systems within PMCC.

Knowledge of health-care financing in general and health insurance in particular in

the context of recent global and national initiatives is a unique national resource. The PMCC should lead in the development of national expertise and consensus in this field. Its staff, who exhibit an already impressive level of commitment, must be provided with stronger technical skills and supported with an up-to-date information system. The board's present interagency mix can be enhanced by sectoral representations to generate national consciousness and consensus for reforms in health-care financing.

MEDICARE'S IMPACT ON THE HEALTH SECTOR

This assessment will be made with respect to the program's ability to act as a risk-sharing mechanism, to widen access to health services and improve equity, to link public financing with private pension, and to help finance current and future health-care needs.

Ability to Act as a Risk-Sharing Mechanism

Medicare as a risk-sharing mechanism was made possible by the concept of mandatory affiliation (Ron *et al.* 1990), whereby legislation made membership compulsory for public-sector and private-sector employees. Contributions collected from members by the two systems are pooled for use when a member has to be hospitalized.

One influence of Medicare in the provision of health services in the Philippines is the introduction of the concept of cost sharing (Solari 1988). Medicare benefits are intended to cover only at most 70% of a patient's medical expenses, with the balance paid for by the individual. Hence, the person's total share is his premium contribution and his out-of-pocket expense. Solari contends that this cost-sharing principle is important because of the limited resources of the government.

However, the risk sharing can stand improvement. Medicare has yet to cover all the employed, having reached only about 22% of them as of 1990, and still does not cover the unemployed, as has already been

mentioned. Moreover, the support values of Medicare have not been as responsive as expected, resulting in the individual paying a larger part of his expenses. This has led quite a few to take out other insurance options.

The coverage of the unemployed and the self-employed is the target of Medicare Program II. DOH and PMCC are taking measures to address the many, complex obstacles to the implementation of Program II. There is an opportunity to expand the coverage of Program I to include the self-employed who are at the lower end of the income spectrum (such as jeepney and tricycle drivers and market vendors). Presidential Decree No. 1636 of 1980 allows the SSS to cover the self-employed, and many of these have indicated a desire for coverage. One impediment to such is the SSS rule that does not allow membership in SSS for purely Medicare purposes. One has to be covered for the entire gamut of SSS benefits (such as retirement, ECC). If this SSS restriction can be done away with (although it may require amending the SSS charter), then the risk-sharing mechanism of Medicare can be enhanced in terms of persons covered.

Despite the legal mandate covering all employees, the inability of the SSS and the GSIS to fully attain this mandate reflects the complex administrative tasks involved. Updating membership records and running after companies that fail to remit contributions are examples of administrative responsibilities that partly explain the increasing operating costs of the program. They also contribute to the inability of Medicare to achieve the full potential of its risk-sharing function.

Ability to Widen Access to Health Services and Improve Equity

A positive feature of the Medicare program is the financial access to health services that it gives beneficiaries (Solari 1988). However, a study by Lugue (1988) indicated that generally Medicare and the ECC have not significantly improved access to health care. He observed that health care demand would have been the same, whether

or not Medicare and ECC were around. Other studies (Ching 1989; Akin *et al.* 1984) show that health care demand in the Philippines is price-inelastic, reinforcing Lague's assertion.

As designed, the Medicare program primarily addresses personal health-care needs. These include services that focus on and benefit the individual directly, such as consultations, hospitalization, and immunization, as opposed to community health care that benefits the community as a whole, such as vector control and environmental sanitation.

The limitation of the current program is its failure to provide for out-patient services. A major reason for this is the PMCC's concern that expanding benefits without adequate controls may worsen abuse of the program. The PMCC embarked on its HMO tie-up to expand the scope of its benefits. Research could be done on the possibility of extending Medicare benefits to out-patients.

Medicare has met with mixed success in improving equity. If equity were viewed from the perspective of premium cross-subsidy (high earners and low earners sharing proportionately in costs), then the regressive structure of Medicare's premium contribution does not enhance equity. But if equity were measured from the standpoint of the healthy members subsidizing the sick, or individuals without family responsibilities supporting retirees or those with spouses and children, then Medicare promotes equity.

Based on the equity standard, Medicare continues to be accused of being unable to expand coverage to the unemployed and to large segments of the self-employed. Moreover, as an employer, the government currently shoulders half of the premium of public-sector employees, a privilege not extended to the unemployed and the self-employed. When public-sector employees and their dependents need medical services, they can use their Medicare benefits and have access to government health facilities. In contrast, the unemployed and the self-employed can count only on government facilities and no Medicare.

Linking of Public Financing with Private Provision

The Medicare program has distinguished itself in this area by virtue of the system's inherent design. Beneficiaries have a choice between private and public hospitals. PMCC records show that as of 1990, a total of 1,506 public and private hospitals were accredited, representing 82% of the estimated 1,846 hospitals nationwide in 1987. Of the hospitals accredited in 1990, 650 were primary hospitals, 605 were secondary, and 251 tertiary. Moreover, the PMCC data indicate that in 1990, 11,336 doctors were accredited, representing 21.5% of the 53,556 registered physicians in the country in 1986 (*CRC Factbook 1990*). It should be noted that the number of registered physicians includes those who have died, are abroad, or are not in active practice.

The PMCC-HMO tie-up is an ongoing experiment in Metro Manila to explore the use of private health maintenance organizations in providing in-patient and out-patient services to Medicare members. It indicates opportunities for improvements throughout the program, if the administrative and technical capacities of PMCC and the two systems become flexible and responsive to changing conditions.

Assistance in the Financing of Current and Future Health-Care Needs

As the previous analyses and discussions indicate, the extent to which Medicare can respond to current and future needs rests largely on reforms it can undertake. Benefits can be restructured, premium contributions can be made more equitable, administrative and management systems can be strengthened.

The current impact of Medicare in promoting improved use of resources through cost containment and quality delivery is limited. This is largely reflected in the limited policies and initiatives in these areas. These are important considerations, since the financing of health needs does not merely imply additional resources but also

means efficiency, effectiveness, and equity in the use of resources and the delivery of services.

AREAS FOR FURTHER CONSIDERATION AND RESEARCH

The enhancement of Medicare benefits is a primary concern. The support of in-patient services alone may be promoting inappropriate use. If people are to appreciate and continue supporting Medicare, it must respond to their needs. Benefit improvements can include higher support value and expansion to include out-patient services. Studies can be done to achieve these objectives, with the added guidelines that corresponding control mechanisms against abuse be set in place and that maternal and child health services (such as immunization and prenatal and postnatal care) be emphasized.

The full coverage of the employed sector must be studied. However, the coverage of the nonformal sector of the population is obviously also a major area of concern which is already being addressed by the DOH.

A policy decision must be made regarding the appropriate contribution structure and the adequate level of reserves. This is a crucial area of research which will help policymakers understand the nature of the tradeoffs involved in enhancing members' benefits now versus providing for financial stability so as to be able to respond to the members' future needs. An alternative to the current regressive structure of contribution also needs to be explored.

The method of reimbursement for hospitals, physicians, and other providers should be a means of promoting cost containment, strengthening quality of services, and encouraging the creation and optimal use of medical resources. Ways must be sought to link the reimbursement mechanisms to both public and private providers in underserved areas, and to specialty types, rather than type of hospital. A reimbursement mechanism along

diagnostic-related groups (DRG) lines may be explored. Moreover, information systems should be structured to promote the evolution of this type of reimbursement.

The extent to which Medicare currently supports the operation of certain facilities as a major revenue source will also help us understand Medicare's impact on the country's health-service delivery. To this end, the annual PMCC hospital cost survey can be institutionalized.

A heavier burden of reform, however, falls on the administration of the HIF. Economies of scale and scope that can be realized from an integrated system of administration, financing, and reimbursement also need to be studied. Such a study should indicate the appropriate organizational structure of the PMCC and provide for its evolution into

such a structure. Should the current structure be found adequate, the possibility of cross-subsidy between the SSS and the GSIS, between low-income earners and high-income earners, and possibly between Programs I and II must be assessed. Uniform claims processing and monitoring should also be in place. In addition, a stronger system to lessen abuse should be established.

To summarize, other areas of inquiry are:

- Reasons for variations in benefit payments, length of confinement, and utilization-rate experience of SSS and GSIS. This study can indicate the health-seeking behavior of PMCC members such as their hospital preferences, types of illness, and types of medical expenses incurred. This study can also give

insights into provider behavior (such as doctors' prescribing patterns and hospital pricing policies).

- Analysis of the PMCC membership by industry sector and region. This can help explain low compliance rates, particularly for the SSS, and help formulate better collection strategies.
- Evaluation of the possibility of common regional claims processing centers for SSS and GSIS to shorten the processing period for GSIS and at the same time lower the administrative costs of decentralization for both SSS and GSIS. Moreover, shared processing will allow for the development of common standards for claims evaluation for both systems (unlike the present setup where the same claim may be adjudicated differently by the two systems).

THE EMPLOYEES COMPENSATION COMMISSION

INTRODUCTION

The Employees Compensation Commission (ECC) was established by Presidential Decree 626 on December 27, 1974, and took effect on January 1, 1975, supplanting the old Workmen's Compensation program. The EC program provides income, funeral, medical, and related benefits to employees and their dependents in case of work-related death or disability. The benefits come in the form of cash in case of disability or death, medical and related services for injury and sickness, and rehabilitation services in case of permanent disability.

The EC program is administered in much the same way as the Medicare program. Policies are set by the ECC, whose board is composed of the secretary of the Department of Labor and Employment as chairman, the GSIS general manager, the SSS administrator, the PMCC

chairman, and two other members (representing employees and employers) appointed by the President for a term of six years:

Unlike the Medicare premium, the entire ECC contribution is paid by the employer and goes into the State Insurance Fund (SIF). There are two distinct SIFs—one managed by the SSS for privately employed workers, and another handled by the GSIS for state workers. SSS and GSIS also collect premiums and process and pay claims separately.

PROGRAM COVERAGE

ECC coverage is compulsory for all employees 60 years old and under. Older employees who have not been compulsorily retired and who have been paying contributions before the age of 60 may also

be covered. Table 18 shows the membership profile of the program.

In 1987, the ECC covered about 12.2 million workers, or about 59% of all those employed that year, versus 22% for Medicare. About 21% of the population in 1987 were covered by ECC. Medicare's higher percentage of coverage of the population (38%) was accounted for by the fact that it covered not only employees but also their dependents, retirees, and a portion of the self-employed.

SSS covers more members than GSIS and its membership grows at a faster rate. SSS members increased from about 3.8 million in 1976 to 10.9 million in 1987, for an average annual rate of 6%. But the membership rates have been declining, from peak growth rates of 8% to 10% during the early years to 3% in 1987.

GSIS increased its membership from

Table 18 Program Coverage: Employees Compensation State Insurance Fund (ECSIF) (In Thousands)

Year	SSS ECSIF Membership				GSIS ECSIF Membership				Total ECSIF Membership			
	No.	% Change	SSS Medicare Members	% ECSIF to Medicare	No.	% Change	GSIS Medicare Members	% ECSIF to Medicare	No.	% Change	% ECSIF to Medicare	% of Total Employed
1976	5,772	-	2,290	252.05	790	-	790	100.00	6,562	-	213.05	46.21
1977	6,350	10.01	2,520	251.98	830	5.06	830	100.00	7,180	9.42	214.33	50.21
1978	6,977	9.87	2,780	250.97	870	4.82	870	100.00	7,847	9.29	214.99	48.74
1979	7,612	9.10	3,030	251.22	950	9.20	940	101.06	8,562	9.11	215.67	52.85
1980	8,289	8.89	3,300	251.18	1,090	14.74	1,050	103.81	9,379	9.54	215.61	57.19
1981	8,774	5.85	3,500	250.69	1,180	8.26	1,060	111.32	9,954	6.13	218.29	57.21
1982	9,279	8.76	3,700	250.78	1,270	7.63	1,140	111.40	10,549	5.98	217.95	60.98
1983	9,785	5.45	4,240	230.78	1,330	4.72	1,200	110.83	11,115	5.37	214.32	57.89
1984	10,134	3.57	4,410	229.80	1,430	7.52	1,280	111.72	11,564	4.04	203.23	59.00
1985	10,384	2.11	4,510	229.45	1,470	2.80	1,470	100.00	11,818	2.20	197.63	59.69
1986	10,572	2.16	4,720	223.98	1,270	-13.61	1,390	91.37	11,842	0.20	193.81	57.77
1987	10,898	3.08	3,240	336.36	1,280	0.79	1,280	100.00	12,178	2.84	269.42	58.55
Average		6.26				4.72				5.83		

Source: CRC Philippine Health Care Factbook 1990

790,000 in 1976 to 1.2 million in 1987, registering an annual average growth rate of 5%. The highest growth rate was 14.8% in 1980; the lowest was -14% in 1986, probably as a result of the government reorganization. In 1987, the coverage grew by a negligible 0.79%.

However, Table 18 shows a curious fact. Medicare and ECC are expected to cover more or less the same number of workers. In 1987, this was true of GSIS. Medicare and ECC each covered 1.28 million. But under SSS, 10.89 million were reportedly covered by ECC, while only 3.24 million were covered by Medicare when it should, in fact, cover more workers than ECC since it extends benefits to the self-employed. It is possible that the ECC's 10.89 million were listed members, some of whom were no longer working or had failed to remit their contributions, while the 3.24 million recorded for Medicare referred only to active members, who regularly paid their contributions.

CONTRIBUTIONS AND BENEFIT PAYMENTS

Table 19 shows the contribution structure for SSS members, which is based on a fixed percentage of the monthly salary. The 1% monthly salary credit remitted by employers means a contribution for each employee ranging from ₱0.25 to ₱10. (The employer's contributions can be seen as a smaller tax burden on the employer than Medicare, because of the lower maximum income ceiling.) GSIS members, through their employer, also contribute 1% of their monthly salary, up to a maximum contribution of ₱30. This discrepancy between the SSS and GSIS contribution levels becomes more significant particularly when related to the average benefit payments of the two systems, as will be discussed later on.

Table 20 (page 31) gives a profile of ECC contributions. Contributions to the SSS grew from about ₱85 million in 1976 to ₱257 million in 1987, at an average annual rate of 10%. These contributions were only about 54%, on the average, of SSS' Medicare collections.

Table 19 Structure of SSS Contributions

Income Bracket	Monthly Salary Range	Salary Credit	Employer's Share
1	1.00 - 49.99	25.00	0.25
2	50.00 - 99.99	75.00	0.75
3	100.00 - 149.99	125.00	1.25
4	150.00 - 199.99	175.00	1.75
5	200.00 - 249.99	225.00	2.25
6	250.00 - 349.00	300.00	3.00
7	350.00 - 499.99	425.00	4.25
8	500.00 - 699.99	600.00	6.00
9	700.00 - 899.99	800.00	8.00
10	900.00 - over	1,000.00	10.00

Source: Tan 1990

For the GSIS, ECC contributions grew from ₱20 million in 1976 to ₱217 million in 1987, for an average annual rate of growth of 31%—three times that of SSS. But this growth has been erratic, with negative growth in 1978 and positive growth of from 1.75% in 1981 to 182% in 1976. The ECC contributions were only about 56% of GSIS' Medicare collections, for a slightly better performance than SSS'.

On the whole, ECC contributions grew at an average of 16% and were about 55% of Medicare collections. We recall from Table 8 that Medicare collections by the two systems grew at a slightly slower 15% but has been recovering in recent years. Unfortunately, no data for the last three years are available. The slow growth of ECC collections, despite a bigger membership base, highlights the problems of employer compliance and low employer contributions due to low salary ceilings.

The second part of Table 20 examines the ECC benefit payments made by the two systems out of their SIFs. SSS' ECC benefit payments grew at an average annual rate of 20%, ranging from ₱10.3 million in 1976 to ₱88.6 million, or about 17% of its Medicare payments. The average rate of growth of 20% was almost twice the rate of increase of contribution incomes but was much lower than the 52% average rate of growth of GSIS' ECC benefit payments. The largest increases in ECC benefit payments were posted in 1976-77, after which the rate

declined. GSIS' ECC benefit payments were only 52% of its Medicare benefit payments, compared to SSS' 17%.

For the two systems, ECC benefit payments have been growing at 32% and, in absolute terms, have averaged only about a third of Medicare's.

STRUCTURE OF ECC BENEFITS

The EC program provides the following benefits:

- **Medical care**, including hospital expenses incurred by the employee in a ward confinement and for medicines, laboratory and X-ray examinations, nursing services, use of operating room, other ancillary services, and professional fees. These ECC benefits are similar to but higher in ceiling than the Medicare benefits.

The employee shoulders the excess cost of admission to a more expensive room than a ward. Moreover, ECC compensates surgeons and anesthesiologists according to its own RVS, which follows the RVS of PMCC or that of the Philippine College of Surgeons, whichever is higher.

With the implementation of PD 1921

Table 20 Contributions Received, Benefits Paid, and Average Values Paid per Claim by the Employees Compensation Commission, 1976-87

Contributions Received

Year	SSS ECSIF Contributions				GSIS ECSIF Contributions				Total ECSIF Contributions			
	Amount (Thousand Pesos)	% Change	Medicare Collection (Thousand Pesos)	% of Contributions to Medicare Collection	Amount (Thousand Pesos)	% Change	Medicare Collection (Thousand Pesos)	% of Contributions to Medicare Collection	Amount (Thousand Pesos)	% Change	Medicare Collection (Thousand Pesos)	% of Contributions to Medicare Collection
1976	84,998	14.60	140,660	60.43	20,400	182.35	71,720	28.44	105,398	47.07	212,380	49.63
1977	97,409	12.14	155,380	62.69	57,600	30.90	73,900	77.94	155,009	19.11	229,280	67.64
1978	109,231	15.36	173,740	62.87	75,400	-10.61	77,540	97.24	184,631	4.76	251,280	73.48
1979	126,014	11.56	264,670	47.61	67,400	7.12	138,210	48.77	193,414	10.02	402,880	48.01
1980	140,586	8.55	290,550	48.39	72,200	11.31	156,170	46.23	212,786	-28.28	446,720	47.63
1981	145,605	7.17	313,720	48.64	-	1.75	180,940	0.00	152,605	67.98	494,660	30.85
1982	163,546	6.00	330,780	49.44	92,800	29.40	190,050	48.83	256,346	7.92	520,830	49.22
1983	173,353	7.79	340,600	50.90	103,300	12.21	212,600	48.59	276,653	5.53	553,200	50.01
1984	186,851	4.77	342,400	54.57	105,100	42.79	233,900	44.93	291,951	13.64	576,300	50.66
1985	195,766	1.18	332,800	58.82	136,000	30.72	181,500	74.93	331,766	5.70	514,300	64.51
1986	198,074	29.57	335,200	59.09	152,600	-	190,700	80.02	350,674	35.33	525,900	66.68
1987	256,650	9.89	546,200	46.99	217,900	-	278,100	78.35	474,550	15.73	824,300	57.57
Annual Average				54.20				56.19				54.66

Benefits Paid

Year	SSS ECSIF Contributions				GSIS ECSIF Contributions				Total ECSIF Contributions			
	Amount (Thousand Pesos)	% Change	Medicare Collection (Thousand Pesos)	% of Contributions to Medicare Collection	Amount (Thousand Pesos)	% Change	Medicare Collection (Thousand Pesos)	% of Contributions to Medicare Collection	Amount (Thousand Pesos)	% Change	Medicare Collection (Thousand Pesos)	% of Contributions to Medicare Collection
1976	10,341	40.49	161,700	6.40	3,500	108.57	85,120	4.11	13,841	57.71	246,820	5.61
1977	14,528	30.55	137,570	10.56	7,300	258.90	87,540	8.34	21,828	106.92	159,398	9.70
1978	18,966	29.06	178,190	10.64	26,200	-11.83	85,740	30.56	45,166	5.34	223,356	17.11
1979	24,477	19.69	208,530	11.74	23,100	58.87	106,120	21.77	47,577	38.72	256,107	15.12
1980	29,297	23.43	203,830	14.37	36,700	13.09	114,820	31.96	65,997	17.68	269,827	20.71
1981	36,462	8.69	214,680	16.84	41,500	33.98	125,050	33.91	77,662	22.20	292,342	22.86
1982	39,306	25.70	251,500	15.63	55,600	62.41	128,230	43.36	94,906	47.21	346,406	24.99
1983	49,407	19.47	259,100	19.07	90,300	38.10	141,200	63.95	139,707	31.51	398,807	34.90
1984	59,027	14.56	241,200	24.47	124,700	40.90	173,200	72.00	183,727	32.44	424,927	44.34
1985	67,623	18.37	265,100	25.51	175,700	13.49	174,000	100.98	243,323	14.98	508,423	55.41
1986	80,381	10.31	280,300	28.68	199,400	7.37	170,900	116.68	279,781	8.22	560,081	62.01
1987	88,668	20.07	350,200	25.32	214,100	51.99	224,600	95.33	302,768	31.91	652,968	52.67
Annual Average				17.44				51.91				30.45

Source: CRC Philippine Health Care Factbook 1990

on June 1, 1984, an employee hospitalized as a result of a work-related injury could claim benefits from both ECC and Medicare. ("Double recovery" of lifetime pension from ECC and SSS/GSIS is also allowed.) GSIS has honored double-recovery claims since the law took effect, while the SSS started doing so only in late 1989.

- Rehabilitation benefits, in case of work-related disability, covering medical-surgical management, hospitalization, necessary appliances and supplies, and

vocational training and job-placement assistance. Domiciliary care, when required, can be provided by an accredited physician, whose fee should not exceed P60 on the first visit and P50 on subsequent visits. Ambulatory care is also covered up to a maximum of P60 a day, excluding medicines.

- Disability benefits for temporary total disability, permanent total disability, or permanent partial disability. The temporarily disabled employee is entitled to an income benefit of up to P90 daily,

equal to 90% of the average daily salary credit for every day of disability.

For permanent disability, a distinction is made between permanent partial disability and total disability. For total disability, the employee is entitled to a lifetime monthly income, plus 10% of the amount for each dependent child up to a maximum of five children. Income benefit for partial disability is paid for a certain period depending on the nature and extent of the disability and ranging from three months for the loss of a toe, to

50 months for loss of hearing in both ears or the loss of an arm. In addition, SSS gives ₱350 monthly and a "13th month pay," both of which GSIS does not give.

The employee's beneficiaries receive a monthly benefit equal to the monthly income benefit, plus 10% of this amount for each dependent child up to a maximum of five children. This benefit is paid for a maximum of 60 months.

- **Funeral benefits**, which are given to the spouse or children/beneficiaries of the deceased ECC member. The SSS now pays ₱6,000, while GSIS grants ₱3,000.

Table 21, which is based on limited data, shows the distribution of medical benefits to which SSS members are entitled. Medical services composed the bulk of total benefits paid between 1976 and 1987, with an average of 28%. The highest share was recorded at 33.6% in 1984; the lowest, at 15% in 1987.

Payments for disability benefits

accounted for an average of 13% of total benefits paid during the same period but have been on the rise in absolute amounts, unlike payments for medical services.

Composing a mere 0.97% of benefits paid, rehabilitation services had the most dramatic increase, from ₱19,000 in 1980 to ₱4 million in 1987. These services are a distinguishing feature of the EC program which the Medicare program could well consider making part of its own benefit package.

On the whole, medical benefits averaged only 39% of ECC benefit payments. The rest probably took the form of income support in cash, paid directly to the beneficiary, unlike medical benefits which can be reimbursed to providers.

For the SSS, the benefits paid per claim rose by an average of 25% between 1976 and 1987 (Table 21). This was a relatively fast rate when compared to SSS' Medicare benefits (Table 9), which grew at only about 3% during the 1976-87 period. From 1979 onwards, the average benefits paid per claim for ECC were greater in absolute terms than those paid for Medicare.

FUND UTILIZATION

Table 22 (page 33) shows SIF utilization trends for the two systems.

In 1988, SSS paid ₱61 million in benefits, almost one-half the ₱117 million paid by GSIS that year. Benefits paid per claim between 1975 and 1988 averaged ₱804 for SSS and a considerably higher ₱5,461 for GSIS. This substantial difference in expenses, despite the wider coverage of SSS (10.5 million) than GSIS (1.27 million) in 1987, is ascribed by an ECC official to GSIS' coverage of higher-risk groups (members of the armed forces and the police force) and to a disparity in computation formulas prescribed by law, as follows:

COMPUTATION FORMULA

BASIS OF PAYMENT	SSS	GSIS
Average monthly salary credit	Average salary over the last 5 years	Average salary over the last 3 years
Average daily salary credit	Average over the last 6 months	Actual current month

Table 21 **Benefits Paid and Distribution of Benefits by Type of Services**
SSS Employees Compensation State Insurance Fund (ECSIF)

Year	Total (Thousand Pesos)	Ave. Benefits Paid per Claim (Pesos)	% Change	Types of Medical Benefits						% Share of Medical Benefits in Total Benefits Paid
				Rehabilitative Services (Thousand Pesos)	% Share in Total Benefits Paid	Disability (Thousand Pesos)	% Share in Total Benefits Paid	Medical Services (Thousand Pesos)	% Share in Total Benefits Paid	
1976	10,341	182				1,166	11.28	2,546	24.62	35.90
1977	14,528	206	13.19			1,650	11.36	3,962	27.27	38.63
1978	18,966	263	27.67			2,341	12.34	5,423	28.59	40.94
1979	24,477	307	16.73			3,172	12.96	6,980	28.52	41.48
1980	29,297	412	34.20	19	0.06	4,277	14.60	7,428	25.35	40.02
1981	36,162	432	4.85	64	0.18	4,680	12.94	11,497	31.79	44.91
1982	39,306	418	-3.24	77	0.20	6,364	16.19	9,920	25.24	41.62
1983	49,407	571	36.60	279	0.56	7,617	15.42	13,871	28.07	44.06
1984	59,027	759	32.92	629	1.07	8,024	13.59	19,839	33.61	48.27
1985	67,623	1,300	71.28	166	0.25	8,651	12.79	21,989	32.52	45.56
1986	80,381	1,769	36.08	284	0.35			23,541	29.29	29.64
1987	88,688	2,249	27.13	4,493	5.07			14,121	15.92	20.99
Average			24.78		0.97		13.35		27.57	39.33

Source: CRC Philippine Health Care Factbook 1990

Table 22 Utilization of the Employees Compensation State Insurance Fund, 1975-88

Year	Benefit Payments				Administrative Expense				Contribution to ECC Operations				Total Expenses						Claims Paid										
	Amount (Million Pesos)		% of Contribution Income		Amount (Million Pesos)		% of Contribution Income		Amount (Million Pesos)		% of Contribution Income		Amount (Million Pesos)		% of Benefit Payments		% of Administrative Expense		% Contribution to ECC Operations		No. of Claims Paid		Benefit Payment per Claim (Pesos)		Administrative Expense per Claim (Pesos)		ECC Operating Expense per Claim (Pesos)		
	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS
1975	4	0	6.78	0.00	0.30	1.00	0.51	3.03	0.30	0.30	0.51	0.91	4	2	100.00	0.00	7.50	50.00	7.50	15.00	22,998	366	173.93	0.00	13.04	2,732.24	13.04	819.67	
1976	10	3	11.76	6.98	0.70	2.30	0.82	5.35	1.00	1.00	0.18	2.33	12	6	83.33	50.00	5.83	38.33	8.33	16.67	56,697	2,019	176.38	1,485.88	12.35	1,139.18	17.64	495.29	
1977	15	7	15.46	13.21	1.00	2.00	1.03	3.77	1.00	1.00	1.03	1.89	17	10	88.24	70.00	5.88	20.00	5.88	10.00	70,335	2,992	213.27	2,339.57	14.22	668.45	14.22	334.22	
1978	18	20	16.51	23.53	0.50	5.50	0.46	6.47	1.00	1.00	0.92	1.18	20	26	90.00	76.92	2.50	21.15	5.00	3.85	72,180	6,521	249.38	3,067.01	6.93	843.43	13.85	153.35	
1979	24	30	19.05	33.33	0.50	7.50	0.40	8.33	1.00	1.00	0.79	1.11	26	37	92.31	81.08	1.92	20.27	3.85	2.79	79,816	7,160	300.69	4,189.94	6.26	1,047.49	12.53	139.66	
1980	29	33	20.57	42.31	0.60	8.40	0.43	10.77	1.40	1.00	0.99	1.28	31	43	93.55	76.74	1.94	19.53	4.52	2.33	71,180	11,751	407.42	2,808.27	8.43	714.83	19.67	85.10	
1981	36	41	23.53	40.59	3.00	13.00	1.96	12.87	2.00	1.00	1.31	0.99	41	56	87.80	73.21	7.32	23.21	4.88	1.79	83,751	12,687	429.85	3,231.65	35.82	1,024.67	23.88	78.82	
1982	39	55	23.93	55.56	3.00	3.00	1.84	3.03	2.00	2.00	1.23	2.02	45	60	86.67	91.67	6.67	5.00	4.44	3.33	94,023	13,433	414.79	4,094.39	31.91	223.33	21.27	148.89	
1983	49	91	28.32	72.22	3.00	7.00	1.73	5.56	2.00	2.00	1.16	1.59	55	97	89.09	93.81	5.45	7.22	3.64	2.06	86,456	15,813	566.76	5,754.76	34.70	442.67	23.13	126.48	
1984	59	125	31.55	116.82	9.00	13.00	4.81	12.15	3.00	2.00	1.60	1.87	71	140	83.10	89.29	12.68	9.29	4.23	1.43	72,208	20,013	817.08	6,245.94	124.64	649.58	41.55	99.94	
1985	68	175	34.69	134.62	6.00	5.00	3.06	3.85	5.00	2.00	2.55	1.54	78	183	87.18	95.63	7.69	2.73	6.41	1.09	52,015	24,711	1,307.00	7,081.87	115.35	202.34	96.13	80.94	
1986	80	200	40.40	130.72	8.50	5.00	4.29	3.27	4.30	3.20	2.17	2.09	93	208	86.02	96.15	9.14	2.40	4.62	1.54	45,446	12,875	1,760.00	15,533.98	187.04	388.35	94.62	248.54	
1987	89	213	34.63	99.53	9.00	5.00	3.50	2.34	4.30	2.50	1.67	1.17	102	213	87.25	100.00	6.62	2.35	4.22	1.17	39,452	22,228	2,256.00	9,582.51	228.13	224.94	108.99	112.47	
1988	61	117	46.56	121.88	4.40	4.50	3.36	4.69	1.50	1.30	1.15	1.35	67	122	81.04	95.90	6.57	3.69	2.24	1.07	28,013	10,593	2,178.00	11,045.03	157.07	424.81	53.55	122.72	
Annual Average			25.27	63.66			2.01	6.11			1.23	1.52			88.97	77.89	6.42	16.08	4.98	4.57			804.00	5,461.49	69.71	766.16	39.58	217.58	

Source: Employees Compensation Commission

Table 23 Financial Performance and Utilization of the Employees Compensation State Insurance Fund, SSS and GSIS

Year	Members' Contribution (Million Pesos)		ECSIF Revenues								ECSIF Expenses								Reserves											
			% of Total Revenue		Investment Income (Million Pesos)		% of Total Revenue		Total		Benefit Payments (Million Pesos)		Admin. Expenses (Million Pesos)		Contrib. to ECC Operations (%)		Total Disbursement (Million Pesos)		Net Insurance Gain (Million Pesos)		Net Income (Million Pesos)		Amount (Million Pesos)		% Change		Share in Total SIF (%)		Reserve Capacity (Years)	
	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS	SSS	GSIS
1975	59	33	96.72	97.06	2	1	3.28	2.94	61	34	4	0	0.30	1.00	0.30	0.30	4.00	2.00	55	31.00	95	32.00	57	32	145.61	134.38	63.99	36.01	14.25	16.00
1976	85	43	89.47	89.58	10	5	10.53	10.42	95	48	10	3	0.70	2.30	1.00	1.00	12.00	6.00	73	37.00	139	42.00	140	75	70.71	70.67	65.19	34.91	11.67	12.50
1977	97	53	82.91	84.13	18	10	15.38	15.87	117	63	14	7	1.00	2.00	1.00	1.00	17.00	10.00	80	43.00	168	53.00	239	128	49.37	43.75	65.23	34.77	14.06	12.80
1978	109	85	78.99	87.63	28	12	20.29	12.37	138	97	18	20	0.50	5.50	1.00	1.00	20.00	26.00	89	59.00	218	71.00	357	181	40.34	14.67	66.06	33.94	17.85	7.08
1979	126	90	74.12	81.82	43	11	25.29	10.00	170	110	24	30	0.50	7.50	1.00	1.00	26.00	37.00	100	53.00	260	73.00	501	211	35.93	27.49	70.33	29.61	19.27	5.70
1980	131	78	66.82	79.59	69	16	32.70	16.33	211	98	29	33	0.60	8.40	1.40	1.00	31.00	43.00	110	35.00	283	55.00	681	269	30.54	31.60	71.62	28.28	21.97	6.26
1981	153	101	61.20	83.47	96	19	38.40	15.70	250	121	36	41	3.00	13.00	2.00	1.00	41.00	56.00	112	45.00	340	65.00	889	351	28.46	11.58	71.55	28.45	21.68	6.32
1982	163	99	55.07	72.79	132	37	44.59	27.21	296	136	39	55	3.00	3.00	2.00	2.00	45.00	60.00	118	39.00	391	76.00	1,142	395	25.66	4.81	74.27	25.73	25.38	6.58
1983	173	126	49.71	80.25	173	32	49.71	20.38	348	157	49	91	3.00	7.00	2.00	2.00	55.00	97.00	118	29.00	460	60.00	1,435	414	26.83	20.29	77.61	22.39	26.09	4.27
1984	187	107	41.01	76.43	268	33	58.77	23.57	456	140	59	125	9.00	13.00	3.00	2.00	71.00	140.00	116	-33.00	541	0.00	1,820	498	35.99	-10.44	78.51	21.49	25.63	3.56
1985	196	130	26.78	87.25	536	18	73.22	12.08	732	149	68	175	6.00	5.00	5.00	2.00	78.00	183.00	118	-53.00	810	-34.00	2,475	416	23.92	-8.30	84.22	15.28	31.73	2.44
1986	198	153	28.41	88.95	498	19	71.45	11.05	697	172	80	200	8.50	5.00	4.30	3.20	93.00	208.00	105	-55.00	791	-36.00	3,067	409	19.40	-0.73	83.24	11.76	32.98	1.97
1987	257	214	36.98	100.00	438	0	63.02	0.00	695	214	89	213	9.00	5.00	4.30	2.50	102.00	213.00	155	1.00	816	1.00	3,652	406	8.47	-4.93	90.00	10.00	35.90	1.91
1988	131	96	34.93	96.97	244	4	65.07	4.04	375	90	61	117	4.40	4.50	1.50	1.30	67.00	122.00	64	-26.00	372	-23.00	3,972	386	38.66	23.92	91.15	8.85	59.28	3.16
Annual Average			58.79	86.14			40.81	13.00									100.93	14.64	406.00	31.07					75.57	24.39	25.55	6.47		

Source: Employees Compensation Commission

SSS, which has substantially more reserves than the GSIS, ironically uses the lower compensation formula. This inequity in computation formulas needs to be addressed, especially since the maximum monthly contribution level for GSIS (P30) is much higher than SSS' (P10).

Administrative expenses represent the costs incurred by the systems in their ECC operations. In 1988, the systems spent about the same: P4.4 million for SSS and P4.5 million for GSIS. But these amounts, when translated into costs per claim for the period 1975-88, meant an average of P766 for GSIS, more than ten times the SSS average (P70). The causes of this wide divergence and its impact on the servicing of beneficiaries should be studied, to improve the overall efficiency and responsiveness of the ECC.

The contribution to ECC operations represents the amounts remitted by the two systems to the ECC secretariat to cover its own operating expenses. The SSS SIF shoulders 60% of the ECC's operating budget, while the GSIS SIF bears 40%. Although an agency's operating costs generally increase over time, Table 22 shows that the P2.8 million remitted by SSS and GSIS in 1988 (P1.5 million and P1.3 million, respectively) was less than the P5.8 million they contributed in 1987 (P4.3 million and P2.5 million, respectively). This unexpected decrease may be explained by possible underreporting of 1988 data.

Between 1975 and 1988, benefit payments made up the largest part of total expenses, averaging 89% for SSS and 78% for GSIS.

FINANCIAL PERFORMANCE

Table 23 shows that between 1975 and 1988, about 59% of SSS revenues came from members' contributions, with investment income accounting for the balance. During the same period, GSIS' main source of revenues was premium collection, which composed 86% of total income on the average.

Investment income as a major funding source for SSS has exhibited steady growth. In 1985, it represented 73% of total revenues, declining to 65% in 1988—still a very respectable share. In contrast, GSIS showed a declining proportion starting in 1985, when the share of investment income in total revenues dipped from 24% to 12%. More unusual still was the zero investment income reported by GSIS for 1987. For 1988, only P4 million was recorded. It is hoped that these statistics are due merely to inaccurate reporting and do not reflect GSIS' investment policies. But if so, the inadequacy lends credence to the observation of an ECC official that the ECC program as a whole sadly lacks a data base and a management information system.

SSS showed a positive net insurance gain and net insurance income for the entire period under review, indicating that members' contributions alone can cover all the expenses of the program. There was, however, a marked decrease in net gain and net income in 1988 compared to 1987.

On the other hand, GSIS registered a negative net gain and net income between 1984 and 1988, except for 1987. Curiously, total revenues for 1984 equalled total expenses for the year, resulting in zero net income. GSIS had a respectable reserve capacity of three years in 1988. It would be interesting to see how GSIS reserves stood in 1991, with the negative trend in net insurance income that started in 1984.

In 1988, SSS had P3.9 billion in its SIF, more than ten times GSIS' P386 million. Especially interesting is the fact that SSS' reserve capacity was 59 years, given 1988 expenses. This capacity appears excessive, and ECC may have to make a policy decision about how it should deal with such a high reserve level. It could decide to increase benefit levels substantially or to reduce premium contributions or suspend premium collection for a time to give employers some relief in this difficult economic period. ECC and Medicare policymakers appear to be faced with the issue of responsiveness versus stability with respect to SSS, that is, how much reserves are needed to ensure program viability while at the same time

giving as much benefits as possible to members.

ECC'S ROLE IN OVERALL HEALTH-CARE FINANCING

OPERATIONAL ISSUES

The absence of an adequate information system within the ECC and the ECC's dependence on the two systems for data constrain decision making on policies and operations. The establishment of such an information system is a worthwhile project.

The ECC's dependence on the two systems for its operating budget—and hence on the speed with which SSS and GSIS remit their share—is a major operating constraint, according to an ECC official. The two systems now make quarterly advances on their obligations, but in the past, one of them remitted the ECC budget at the end of the quarter, causing operating difficulties for ECC, which has no other funding sources.

The medical rehabilitation program of ECC must be strengthened. The service requires specialized medical and paramedical manpower and facilities which may not be available outside the main urban areas of the country, thereby putting at a disadvantage those living in the rural areas. ECC also needs to play a stronger role in ensuring occupational safety.

An HMO official who was interviewed expressed dissatisfaction with the delayed processing of ECC claims. He cited instances where claims took as long as six months to be settled and the service providers to be paid.

OVERALL CONCERNS AND CONSIDERATIONS

By design, the ECC has a limited role in health-care financing. It is focused on workers and confined to work-related injuries. In fact, because ECC medical benefits are not linked to Medicare's, double recovery of benefits from the two systems is possible and allowed legally—a situation

which an ILO study done in 1990 warned could promote absenteeism and thus hamper productivity and endanger the pension funds.

Research can therefore be done on the feasibility of integrating the medical, ambulatory, and rehabilitative services of ECC with Medicare's. PMCC's current benefit coverage can be expanded to include ambulatory and rehabilitative services, which are logical extensions of its benefits to members, and an appropriate percentage of the ECC premium can be turned over to Medicare. In the resulting streamlined social health insurance program, beneficiaries and service

providers will deal with a single institution, and double recovery for the same illness can be avoided.

It remains to be seen whether abuse by providers is as serious a concern for the ECC as it is for Medicare. But, because the use by the ECC and PMCC of different RVS units could confuse service providers, the possibility of adopting a uniform RVS for the two agencies should be studied, as suggested in the chapter on Medicare.

Since the ECC operates in basically the same manner as Medicare, its impact on the escalation of health-care costs and the quality of health services can also be studied

when such research is done for Medicare.

The high reserve capacity of SSS' Medicare and ECC funds raises a fundamental policy issue that needs to be resolved: the extent of social solidarity that is desired in the Philippines. Should there be no distinction between the health benefits of state workers and private-sector employees? If so, then the HIFs of SSS and GSIS for Medicare should be merged, as should the systems' SIFs for ECC. The issue of social solidarity will also guide policy decisions on whether premiums collected from the employed should cross-subsidize the unemployed and the poor.

HEALTH MAINTENANCE ORGANIZATIONS

INTRODUCTION

The health maintenance organization (HMO) is a relatively new and unique organization since it not only finances medical expenses but also provides health care to its enrolled members.

HMOs differ from traditional indemnity health insurance companies in many ways. Traditional medical-expense insurers usually cover only curative out-patient and in-patient care. Many of them charge a deductible expense so that small medical expenses (such as preventive care) need not be included in the benefit package. Aside from deductible expenses, co-insurance and maximum limits are the norm. A percentage of professional fees may also be covered (Reverente 1988).

In contrast, the HMO provides health care directly to its members. In the Philippines, most HMOs neither own hospitals nor employ full-time medical specialists. Instead, they arrange for their enrollees to receive health services from accredited providers. The HMOs usually cover both preventive and curative care; hence, they charge no deductible medical expenses. In return, each member pays a premium called "capitation," which is fixed regardless of the amount of care he receives in a period. Co-insurance and maximum limits apply only to admission to a nonaffiliated hospital or to dread disease. The member pays no professional fees, except for excluded services or for benefit avilment outside the allowed procedures (Reverente 1988).

HMOs can be organized in a variety of ways. The two most common are the prepaid group practice (PGP) and the individual practice association (IPA) models. In the PGP model, salaried physicians serve full time or part time and share equipment and staff at the HMO facility, where they attend to enrollees. In the IPA model, enrollees

receive care from the participating physician of their choice at his own office (Long and Morton 1988).

The HMOs operating in the country follow the IPA model. Even those HMOs that own hospitals do not employ salaried medical specialists to attend to confined patients. They employ residents who go on 24-hour duty and reserve the medical specialists for medical emergencies that the resident on duty cannot handle. However, in the out-patient clinics set up by HMOs, the doctors are normally paid salaries by the HMOs.

The following is a discussion of three types of HMOs in the Philippines: investor-based, community-based, and employer-initiated HMOs. Investor-based HMOs focus on the employed sector and are basically profit-oriented. Community-based HMOs are experimental, nonprofit organizations in lower-income

communities. (The community-based HMOs referred to in this paper are two pilot HMOs supported by USAID and the Philippine Council for Research and Development.) Employer-initiated HMOs are formed by companies solely for their employees or also for their employees' dependents.

INVESTOR-BASED HMOs

NUMBER OF HMOs

Secondary data do not agree on the number of HMOs operating in Metro Manila. Studies by Alfiler (1989a, the primary reference for this section) and by Andersen Consulting (1990) identified 16 investor-based HMOs, which are listed in Table 24. The Solari report, however, mentioned only 12 HMOs operating in 1988.

Table 24 Health Maintenance Organizations (HMOs) in the Philippines

HMO	Date of Incorporation	Start of Operations	Organizational Affiliation
Blue Cross		8/87	Insurance-based
Family Medicare		1st Quarter, 1991	Insurance-based
Family Health Care Plan			Hospital-based
Fortune Care	2/12/85	6/85	Insurance-based
Health Care and Development	3/28/80		Hospital-based
Healthkard International Inc.	1/12/87	5/26/87	Hospital-based
Health Maintenance Inc.	4/29/81		
Health Plan Phil. Inc.	4/86	6/86	
Intercare	2/25/78		
Lifecare	4/4/86	7/86	
Maxicare	4/28/87		Hospital-based
Medicard	11/27/86		
Pamana Golden Care		12/87	
Philam Care	6/17/82	1985	Insurance-based
St. Patrick's	2/25/65	1965	Clinic-based
St. Vincent	7/18/88	1965	Clinic-based
Waterous Medical Corp.	4/2/81		Hospital-based

Source: Alfiler 1989; interview with industry source 1991

According to newspaper accounts, there are from 12 to 26 HMOs.

Table 24 uses data from Alfiler's study. One can easily conclude that the industry is still in the early stages of development, inasmuch as almost all the HMOs in the list, except for St. Patrick's and Intercare, were incorporated and started operating only in the 1980s.

HMOs being both insurers and providers of health services, it is not

surprising to find that the majority trace their roots to insurance companies or hospitals/clinics. Four of the local HMOs that are affiliated with hospitals/clinics (Healthkard Inc., St. Vincent, St. Patrick's, and Waterous Medical Corp.) started out as industrial clinics with clients employed in a specific industry or working overseas.

HMO ENROLMENT

Table 25 lists the age requirements, number of enrollees, and client mix of the

HMOs. The data can change quickly, Alfiler warns, so caution should be exercised in their use. The 16 HMOs in the list cover everyone from infants 15 days to three months old to employees 60 or 65 years old. The profit-oriented HMOs consider retirees too high-risk and therefore exclude them from coverage, even if they allow exceptions to this general policy, especially for prime corporate accounts. The government should therefore give serious attention to the coverage of people over age 60 in the design of a national health insurance program.

Table 25 HMO Clients: Eligibilities, Approximate Enrolment, and Mix

HMO	Membership Eligibilities	Approx. Enrolment		% of Metro Manila Members to Total Membership	Mix (Corporate vs. Individual)
		1989	1991		
Blue Cross	15 days to 65 years provided enrolment is before age 60	5,000			
Family Medicare	30 days to 55 years (terminate at 60 years) for individuals; 30 days to 60 years (terminate at 65) for groups	10,500	50,000	50	Almost all corporate
Family Health Care Plan			Less than 1,000	0	
Fortune Care	3 months to below 65 years	25,000	50,000	80	40% corporate
Health Care and Development	3 months to below 65 years	4,000			100% corporate
Healthkard International Inc.	3 months to below 60 years (terminate at 65)	1,000	130,000-140,000 (regular plan); 45,102 (PMCC tie-up)	15-20 100	
Health Maintenance Inc.	3 months to below 65 years	78,000	35,000		85% corporate
Health Plan Phil. Inc.	3 months to below 65 years		10,000		
Caphealth (Intercare)	15 days to below 60 years	5,000	15,000		100% corporate
Lifecare	3 months to below 65 years	30,000	25,000-30,000		
Maxicare	Less than 65 years				
Medicaid	3 months to below 60 years	18,000	30,000-40,000		
Pamana Golden Care	3 months to below 60 years	90,000	100,000 126,367 (PMCC tie-up)		More than 90% corporate
Philam Care	15 days to below 65 years	80,000	100,000	60	60% corporate
St. Patrick's	Corporate employees	10,000			100% corporate
St. Vincent	3 months to below 65 years	5,000			80% corporate
Waterous Medical Corp.	Corporate employees	14,000			100% corporate
Total (Estimated)		375,500			

Source: Alfiler 1989; interview with industry source 1991; Andersen Consulting study

Table 26 HMO Professionals and Facilities, 1989

HMO	Primary Physician	Total Accredited Doctors (Metro Manila Only)	Accredited Hospitals		HMO Clinics (MM)	Medical Service Units (MSUs)
			Metro Manila	Outside MM		
Blue Cross	13		8	2		8
Family Medicare			21	64	2	21
Family Health Care Plan						
Fortune Care	10 clinic physicians	94	19	8	4	19
Health Care and Development	10	150	10	2		10
Healthkard International Inc.	17	89	15	1		14
Health Maintenance Inc.	26	Approx. 400	13	2	3	13
Health Plan Phil. Inc.	45	165	9	14	1	19
Caphealth (Intercare)	8	156	10			7
Lifecare	32	232	16	12		13
Maxicare	9	135	9		1	9
Medicard	19	235	18	9		1; 8 satellite clinics
Pamana Golden Care			16	12	1	16
Philam Care	23	262	17	23	5	12
St. Patrick's	30 clinic physicians		8			8
St. Vincent			8	5	1	8
Waterous Medical Corp.	12	92 consultants			7	

Source: Alfiler 1989; interview with industry sources 1991

In 1989, the HMOs covered about 375,000 people, or an insignificant 0.63% of the total population of 59,906,000 estimated by the National Statistics Office (NSO). In the first quarter of 1991, HMO enrolment nationwide was placed at between 500,000 and 600,000, or 0.81% to 0.97% of the population. Even with the increase in enrolment, HMOs still cover a negligible portion of the population. Moreover, at least 50% of the HMOs' total enrolment is in Metro Manila, especially if Healthkard's 100,000 to 120,000 enrollees in the U.S. bases were to be excluded from the total. It would be interesting to find out whether the growth in HMO enrolment is being achieved at the expense of commercial indemnity insurance or it represents a real expansion in the number of people covered by some form of risk sharing.

As of August 1990, 85,384 Medicare members (excluding dependents) were covered under the PMCC-HMO tie-up, but the registered applicants in the same period, who were awaiting validation of their PMCC membership, actually reached 173,469

(excluding dependents). Still, these 173,469 applicants were only about 7.8% of the estimated 2.23 million Medicare members based in Metro Manila.

Table 25 also reveals that in 1989, the HMOs catered primarily to corporate clients. Five dealt solely with such clients while the rest served a few individual and family clients as well. The only exception was Fortunecare, which drew 60% of its membership from individuals or families and only 40% from the corporate sector. This bias for corporate clients, which HMOs have maintained, is attributed by Alfiler (1989a) to the HMOs' desire for a wider population base, easier collection and other administrative procedures, and greater stability of corporate contracts, which usually last for a year and are less likely to be terminated earlier.

The U.S. experience indicates that the cost-effectiveness of HMOs is particularly attractive to families with modest incomes (Lewis 1988). A comparison could be made with enrollees of Philippine HMOs

and if the findings are similar, then our policy makers must determine their implications for the coverage of people with low incomes.

HMO-ACCREDITED PROVIDERS

HMO doctors are either paid regular salaries or accredited and paid on a fee-for-service basis, at rates negotiated by the HMO with individual doctors. Salaried doctors serve at HMO-owned out-patient clinics, where medical consultations, minor operations, and diagnostic services are provided. For HMOs that own hospitals, the medical staff may also act as attending physicians of confined patients. Accredited doctors paid on a fee-for-service basis provide specialist out-patient consultations and attend to in-patient cases that are beyond the competence of the HMO's salaried physicians. Accredited doctors normally operate out of their own clinics and in certain hospitals where they have admitting privileges.

Most Philippine HMOs do not own hospitals and lack the capital resources needed to put up hospitals in all the areas of the country where they operate. For this reason, the HMOs accredit hospitals which agree under contract to admit an HMO member according to established procedures. The HMO member is discharged without having to settle his hospital bills, since the HMO guarantees payment. The HMO may be given a discount and a credit line by the hospital.

Most HMOs own out-patient clinics and may accredit other facilities as well. Outside clinics are used when they have diagnostic capabilities that are not available at the HMO-owned clinic. Moreover, outside clinics in strategic locations and in places where there are no HMO-owned facilities may also be accredited. As much as P3 million in capital investment alone is needed to put up one of these clinics.

Table 26 presents the absolute numbers of primary physicians, accredited doctors, hospitals (within and outside Metro Manila),

and clinics/medical service units (MSUs) contracted by the HMOs to serve their clients. In principle, the more providers an HMO contracts, the more physical access it provides to each enrollee and, therefore, the more attractive the HMO becomes to potential clients.

The number of providers contracted by HMOs, given in Table 26, does not vary greatly (compared to the variance in the number of enrollees), especially in terms of the number of primary physicians and HMO clinics/MSUs. These providers are considered critical in the provision of medical care by HMOs, because a primary physician serves as "gatekeeper," taking charge of the initial consultation and checkup, referring the enrollee to a specialist, or recommending hospitalization.

Table 27 shows the number of providers available for every 1,000 enrollees in each HMO. On the average, there are 2.79 primary physicians, 21.92 specialists, and 2.03 MSUs or clinics for every 1,000 enrollees.

According to Table 28 (page 40), Healthkard International, Health Care and Development, Family Medicare, and St. Vincent have the highest provider-to-enrollee ratios, primarily because of their few enrollees. On the other hand, HMOs with more enrollees like Pamana Golden Care, Philam Care, and Health Maintenance Inc. show very low provider-to-enrollee ratios.

High provider-to-enrollee ratios may mean better-quality care and higher enrollee satisfaction because the primary physician has more time for each patient, who will also not have to wait as long to be served at an MSU or clinic. Low provider-to-enrollee ratios, on the contrary, could mean poorer-quality care and lower client satisfaction on account of congested MSUs and clinics and physicians not having enough time for each patient.

Provider-to-enrollee ratios are, however, acknowledged to be inadequate measures of quality. Only a small fraction of enrollees get sick all at one time, so

Table 27 **Service Providers**
Absolute Numbers and per 1,000 Enrollees

HMO	Primary Physicians		Accredited Doctors in Metro Manila		Accredited Hospitals				HMO Clinics (Metro Manila) and MSUs	
	No.	No. per 1,000 Enrollees	No.	No. per 1,000 Enrollees	In Metro Manila		Outside Metro Manila		No.	No. per 1,000 Enrollees
					No.	No. per 1,000 Enrollees	No.	No. per 1,000 Enrollees		
Blue Cross	13	2.60			8	1.60	3	0.60	8	1.60
Family Medicare					21	2.00	64	6.10	23	2.19
Fortune Care	10	0.40	94	3.76	19	0.76	8	0.32	23	0.92
Health Care and Development	10	2.50	150	37.50	10	2.50	2	0.50	10	2.50
Healthkard International Inc.	17	17.00	89	89.00	15	15.00	1	1.00	14	14.00
Health Maintenance Inc.	26	0.33	400	5.13	13	0.17	2	0.03	16	0.21
Health Plan Phil. Inc.	45		165		9		14		20	
Intercare (Caphealth)	8	1.60	156	31.20	10	2.00		0.00	7	1.40
Lifecare	32	1.07	232	7.73	16	0.53	12	0.40	13	0.43
Maxicare	9		135		9				10	
Medicard	19	1.06	235	13.06	18	1.00	9	0.50	29	1.61
Pamana Golden Care					16	0.18	12	0.13	17	0.19
Philam Care	23	0.29	262	3.28	17	0.21		0.29	17	0.21
St. Patrick's	30	3.00			8	0.80	23	0.00	8	0.80
St. Vincent					8	1.60	5	1.00	9	1.80
Waterous Medical Corp.	12	0.86	93	6.64					7	0.50
Average		2.79		21.92						2.03

Table 28 Ranking of HMOs, Based on Number of Providers per 1,000 Enrollees

HMO	Rank					Based on No. of Enrollees
	Based on No. of Primary Phys./1,000 Enrollees	Based on No. of All Doctors/1,000 Enrollees	Based on No. of Hospitals/1,000 Enrollees		Based on No. of Clinics and MSUs/1,000 Enrollees	
			In Metro Manila	Outside Metro Manila		
Blue Cross	3	-	6	4	6	10
Family Medicare	-	-	4	1	3	8
Fortune Care	9	10	9	9	8	5
Health Care and Development	4	2	2	6	2	11
Healthcard International Inc.	1	1	1	3	1	12
Health Maintenance Inc.	10	7	13	12	13	3
Health Plan Phils. Inc.	-	-	-	-	-	-
Intercare (Caphealth)	6	5	10	7	11	4
Lifecare	5	3	3	-	7	10
Maxicare	-	-	-	-	-	-
Medicaid	7	4	7	5	5	6
Pamana Golden Care	-	-	12	11	14	1
Philam Care	11	11	11	10	12	2
St. Patrick's	2	-	8	-	9	9
St. Vincent	-	-	5	2	4	-
Waterous Medical Corp.	8	6	-	-	10	7

Source: Alfiler 1989

congestion at the primary levels of care may not occur. Moreover, enrollees may be unevenly distributed among the various MSUs. The appropriate number of providers per enrollee in an HMO set-up, given morbidity patterns, may be worthwhile looking into. Besides, the above ratios are only meant to be indicative and would have changed by now, with the changing number of enrollees and HMO-affiliated providers.

Benefits

The HMOs commonly offer preventive health care (including annual physical checkups), in-patient services, out-patient services, and emergency care. "Pre-existing conditions," which can be any illness, injury, or medical condition already affecting the member at enrolment, are generally excluded. This is a safeguard against adverse selection, in which the patient enrolls in the HMO and stays in the system only long enough for his illness to be cured. HMOs usually cover pre-existing conditions after one or two years.

The emphasis on preventive and primary care offers many possibilities for HMO-DOH cooperation towards the achievement of the health goals of the government. For example, the HMOs could participate in the government's immunization program. Some HMOs now cover the professional fees for vaccination but the vaccine has to be paid for by the patient. The DOH could make vaccination cheaper by providing the vaccine for free (as in the Expanded Program on Immunization, or EPI) or at nominal cost. The same scheme could be developed for oral rehydration therapy, care of tuberculosis patients, and family planning.

The coverage of preventive and out-patient care by HMOs is believed to help control the escalation of cost. It encourages early detection and treatment of an illness and requires patients to get a referral from their primary physician before going to the hospital, except in emergency cases. An assessment by Karen Davis of the role and impact of HMOs in overall cost containment in the U.S. from 1950 to 1985 was cited in

a later edition of Alfiler's paper (1989b). While HMOs are less costly than traditional alternatives, the rate of increase in their cost per person is similar to trends over time in the fee-for-service sector. Therefore, while HMOs can achieve a one-time downward shift in costs, they do not seem able to slow down the increase in costs over time.

Again, from a policy perspective, it would be interesting to undertake a similar assessment of the impact of Philippine HMOs on health-care costs.

MEMBERSHIP FEES (PREMIUM RATES)

Apart from the degree of actuarial risk, the type of room, the frequency of payment, the number of persons covered, and the supplemental benefits determine the fee charged for membership.

Table 29 on the next page presents average fees for different room accommodations, payment schemes, and number of persons involved, in 1989. Generally, premium rates for semi-private, private, and suite accommodations are about 20%, 70%, and 240% more expensive than for a ward. On the other hand, monthly fee payments are roughly 12% more expensive than annual, 5% more expensive than semi-annual, and 3% more expensive than quarterly payments. Individual plans tend to be about 30% more expensive than corporate plans, while family plans (when computed per family member) are only about 15% more expensive than corporate plans.

SALES FORCES

HMOs generally market their products through individual agents, insurance brokers, an in-house sales staff, or a combination of these.

Individual agents may operate independently or under the life insurance (or pre-need) company with which the HMO is affiliated. They are not on the payroll of the HMO company but are supposed to market only the products of the HMO company with which they are accredited.

Insurance brokers, in contrast, view themselves as working for the benefit of the

Table 29 Average Premium Rates for HMOs, 1989

Coverage Type/ Payment Frequency	Ward	Semiprivate	Private	Suite
Individual				
Annually	830.52	990.40	1,424.23	2,750.10
A	11.98%	13.59%	-2.41%	11.27%
B	31.36%	31.71%	30.27%	28.73%
C		19.25%	71.49%	231.13%
Semiannually	442.10	521.10	748.93	1,463.40
A	5.18%	7.94%	-7.20%	4.55%
B	32.54%	31.33%	29.69%	28.92%
C		17.87%	69.40%	231.01%
Quarterly	225.40	267.60	385.39	749.85
A	3.15%	5.10%	-9.83%	2.02%
B	31.93%	31.00%	34.59%	28.62%
C		18.72%	70.98%	232.68%
Monthly	77.50	93.75	115.83	255.00
B	37.78%	39.05%	16.87%	34.21%
C		20.97%	49.46%	229.03%
Family of Six				
Annually	4,219.20	5,323.90	7,591.33	14,980.85
A	15.54%	11.01%	-0.16%	10.18%
B	11.22%	18.00%	15.73%	16.87%
C		26.18%	79.92%	255.06%
Semiannually	2,319.00	2,857.80	3,754.05	8,112.14
A	5.11%	3.40%	0.94%	1.74%
B	15.87%	20.04%	8.35%	19.11%
C		23.23%	61.88%	249.81%
Quarterly	1,185.90	1,469.60	1,914.76	4,079.91
A	2.77%	0.54%	-1.05%	1.14%
B	15.69%	19.90%	11.45%	16.64%
C		23.92%	61.46%	244.03%
Monthly	406.25	492.50	631.57	1,375.50
B	20.37%	21.75%	6.21%	20.66%
C		21.23%	55.46%	238.58%
Corporate				
Annually	632.26	751.98	1,093.28	2,136.35
A	6.76%	7.59%	8.78%	6.72%
C		18.94%	72.92%	237.89%
Semiannually	333.56	396.79	577.48	1,135.15
A	1.18%	1.95%	2.97%	0.43%
C		18.96%	73.13%	240.31%
Quarterly	170.85	204.28	286.34	582.98
A	-1.23%	-0.99%	3.84%	-2.23%
C		19.57%	67.60%	241.22%
Monthly	56.25	67.42	99.11	190.00
C		19.86%	76.20%	237.78%

Notes:

- A Shows how much more expensive monthly payments are compared to other types of payment
 B Shows how much more expensive individual or family plans are compared to corporate plans
 C Shows how much more expensive the other types of room accommodations are relative to a ward

Source: Alfiler 1989

enrollee. They also are not in the HMO's employ. They may canvass several HMOs and health insurance companies to get the best terms for the consumer. Hence, the HMOs have less control over insurance brokers. The HMO compensates the individual agent and the insurance brokers through a commission computed as a percentage of the premium collected.

The in-house sales staff of HMO companies are regular employees who may be compensated with a fixed salary and some allowances or commissions or both. Generally, the in-house staff primarily target corporate accounts rather than individuals.

An HMO company indicated that most problems they have with their enrollees stem from the latter's lack of understanding of their HMO benefits, especially the coverage of pre-existing conditions. For this, he blamed the inability of sales agents to explain the benefits adequately. The need for consumer education seems to be an industrywide problem which requires serious attention.

FINANCIAL VIABILITY

Until they reach the breakeven enrolment levels they have set for themselves, the HMOs expect to have operating deficits. Working-capital pressure and the need for capital investment in outpatient clinics are the financial difficulties that HMOs face especially during the first few years. Some of the HMOs interviewed said that 55% to 60% of their revenues go to medical services, 15% to 20% to agents' commissions, 20% to administrative costs, and 10% to profits.

OPERATING CONSTRAINTS ON HMOs

The following discussion is the result of personal interviews with some HMO officials. The constraints they cited, which may not apply to all HMOs, include:

- **Problems with hospitals.** Some HMOs feel they are at the mercy of hospital pricing. The ability of hospitals to adjust their prices anytime threatens the HMOs' financial performance, particularly on their existing contracts. Moreover, the

HMOs that do not own hospitals have difficulty containing costs.

Some hospitals are reluctant to enter into tie-ups with HMOs, making it difficult for the HMOs to expand their services. The HMOs admit, however, that unpleasant experiences with some HMOs (such as delays in payment of accounts) were responsible for the sometimes negative attitude of providers.

- **Problems with doctors.** Doctors are not fully receptive to HMOs. Some fear the loss of patients that could result from nonaccreditation and the prospect of reduced income with the fees negotiated by HMOs, which are lower than the prevailing fee-for-service rates.

The HMOs also find it difficult to control costs by reviewing physicians' practice patterns. Doctors view any audit of patients' charts, done to determine the reasonableness of prescriptions and diagnostic procedures, as an unwelcome intrusion.

- **Government taxation.** The AHMOPI believes that the 10% value-added tax on the sale of services does not apply to HMOs.
- **Lack of trained personnel and inadequate systems.** Many HMOs have expressed the need for trained managers and improved systems and procedures for dealing with the administrative complexities of running an HMO. While foreign training may have its advantages, the HMOs emphasized that it must be adapted to the Philippine situation. The HMOs also indicated the need for updated data on utilization and costs, as well as membership and claims processing procedures.
- **Beneficiary education.** Beneficiaries must be better informed about privileges, exclusions, and availment procedures to forestall complaints, which mostly arise from ignorance. Some HMOs feel that the general public does not know enough about HMOs and the advantages they provide.
- **Proper mix of marketing staff.** One

HMO said that they are still determining the proper mix of salaried in-house staff and insurance agents in their sales force.

- **Unrealistic pricing by competitors.** Some HMOs pointing to the unrealistic premium rates of some competitors expressed fears for the reputation of the industry, should those HMOs become insolvent. They urged the government to step in and protect the general interest. (Areas for government regulation are discussed at greater length in the next section.) To other HMOs, however, low pricing by competitors is a market reality.

POLICY, REGULATORY, AND LEGISLATIVE CONSTRAINTS

Although no government agency oversees the operations of HMOs, the HMOs themselves seem to welcome some form of government regulation provided it is not too restrictive. There was no unanimity among the HMOs interviewed as to which government agency should regulate HMOs. Among the suggestions were:

- **Department of Health.** HMOs finance and deliver health services. Some HMOs therefore deemed regulation by the DOH appropriate, since the DOH, which already regulates hospitals nationwide and is involved in health financing through the PMCC, is effectively involved in both service financing and delivery.
- **Insurance Commission.** An HMO said that the commission had the required experience and capability to regulate HMOs. The commission is now monitoring the compliance of insurance companies with the provisions of the Insurance Code regarding organization, capitalization, and authorization; margin of solvency (excess value of admitted assets over liabilities, unearned premium reinsurance reserves); assets; investments; reserves; limit of single risk; reinsurance transactions; policy forms; variable contracts; claims settlements; and examination of companies. Some of those standards, HMOs contend, may be modified and

applied to HMOs.

- **Securities and Exchange Commission.** Other HMOs suggested that regulation be placed in the hands of the SEC because it can evaluate the financial condition of a company.
- **Self-regulation by industry with DOH as supervisor.** A parallel case cited is that of private security agencies, whose industry association makes rules that govern the members, subject to the approval of the Philippine National Police.

The HMOs suggested two types of government policies and regulations for HMOs: measures to deter fly-by-night operators, and incentives to promote the growth of the industry. The following deterrents were proposed:

- Minimum capital requirements
- Review of the actuarial computations underlying the premium rates charged
- Review of the proportion of administrative costs to premiums

The following industry incentives were recommended:

- Mandatory dual-choice legislation requiring companies to allow their employees to choose between private health insurance and HMO insurance
- Deductibility of HMO membership fees from personal income tax
- Soft loans to new HMOs
- Tax exemptions and tax credits
- Additional incentives for HMOs operating in the provinces
- Tax privilege for importation of medical equipment
- Access to DOH hospitals by private HMOs and insurance companies
- Referral to government facilities of illnesses not covered by HMOs or

illnesses that have exhausted their HMO benefit ceilings, to provide HMOs with a "safety net"

- Nationwide implementation of the Medicare-HMO tie-up
- Official recognition of HMOs as supplemental to the existing health programs of the ECC and the PMCC
- Dialogue between HMOs and health providers especially in fee setting

INDUSTRY PROSPECTS AS VIEWED BY HMOs

The HMOs are generally very optimistic about their growth. Those interviewed projected annual enrolment growth targets of from 20% to 100% for the next few years, knowing full well that, to achieve the targets, they should be more innovative and efficient to be able to offer attractive benefits at affordable premiums. They remain undaunted by the economic crisis and the steeply rising cost of health care.

ELEMENTS OF POSSIBLE HMO LAW

The following elements of a possible law regulating HMOs were discussed with some members of the AHMOPI. Their reactions sprang from the view that:

- HMOs are not insurance companies and, hence, must not be regulated as such
- Regulations must not be unilaterally imposed by the government but must be arrived at in consultation with the HMO industry
- Poorly considered regulations could unduly increase membership fees
- Some of the proposed regulatory elements may be appropriate in other countries but not in the Philippines

Some of the elements (such as quality of care, benefit package, enrolment practices and pre-existing conditions, and mandatory choice) elicited specific comments but no

consensus on their acceptability.

The two main references for this topic are "Evaluation of the Philippine Medicare System: A Trip Report" by Alfredo Solari (1988) and "HMO Regulation in the Republic of the Philippines: A Trip Report" by Roger C. Day (1990). According to these authors, HMO regulations should consider the following areas:

- **Definition of basic features and financing arrangements.** Solari said that the definition, which must be acceptable internationally and yet applicable to the Philippines, would restrict the use of the name "HMO" to only those organizations that meet the definition.
- **Quality of care.** Since an HMO not only allows sharing of medical risks but also provides health services directly or indirectly, the enrollees must be assured that the HMO has the qualified personnel and equipment to provide an acceptable quality of health care. Solari recommended that the DOH set licensing requirements and license HMOs to ensure that their affiliated providers meet the requirements.

To guard against a perceived tendency among HMOs to "undertreat" enrollees, Day, on the other hand, recommended that HMOs be required to maintain a systematic quality assurance mechanism, including at the very least random chart review and evaluation by peers. Among the other mechanisms recommended were assessment of patient and provider complaints, and monitoring of the performance of regular quality reviews.

- **Grievance procedure.** The government must provide enrollees with a venue where they can seek redress of their complaints and be assured of fair consideration. Aside from yielding valuable information about enrollee and provider satisfaction and needed improvements, this procedure would also reduce an HMO's litigation exposure. The government would have to intervene only when the HMO fails to reduce the number of complaints.

- **Benefit package.** Solari proposed that the government set the minimum level of benefits that an HMO should provide to its enrollees. Preventive, curative (both out-patient and in-patient), and rehabilitative services should be part of the package. Day was more specific. He suggested that prenatal obstetrical care and well-baby care be covered, since these are priority needs.

Solari also recommended regulating the exclusion from the benefit package of costly and high-technology procedures and some categories of diseases whose financial consequences may not be evident to the enrollee.

- **Enrolment practices and pre-existing conditions.** Regulation of enrolment practices and pre-existing conditions must not only protect the enrollees but also keep the HMO from being too disadvantaged. According to Solari, HMOs should be allowed to exclude high-risk enrollees or patients with pre-existing conditions to protect HMOs from adverse selection. But for group enrollees, rejection of individuals in the group should not be allowed. Moreover, for individual or family enrolment, only pre-existing conditions that are already known or are uncovered in the initial medical examination should be excluded. If the illness is temporary, it should be excluded until the patient is cured at his own expense; if permanent, it should be excluded for a specified period.
- **Financial soundness and accountability.** The financial performance of HMOs should be regulated in the same way as multipurpose insurance companies. An HMO that has not demonstrated its financial ability to fulfill its responsibilities to its enrollees should not be allowed to operate, Solari said. Even after the HMO is first allowed to operate, its financial performance and accountability must be checked.

To protect the enrollees and make the HMO accountable in the event of its insolvency, Day recommended that HMOs be required to include two provisions in their contracts. The

statutory "hold harmless" provision in the contract between a provider and the HMO stipulates that the enrollee is not liable to the provider for any sum owed by the HMO for services rendered. The "uncovered expenditures insolvency deposit" provision, on the other hand, requires the HMO to deposit a specified amount with an appointed agency if uncovered expenses, or the expenses that the enrollee could be obliged to pay if the HMO becomes insolvent, reach a certain level.

- **Mandatory dual choice.** If the government wishes to encourage the growth of HMOs, it should enact mandatory dual-choice legislation. This requires employers who provide health insurance to their workers to give them a choice between a qualified HMO and traditional health insurance. To encourage competition, different types of HMOs (PGPs and IPAs) should be asked to offer alternative benefit packages. The dual-choice requirement reduces the control of insurance agents and brokers on the market and allows HMOs to compete more in terms of benefit design and price.
- **Advisory committee.** Day also suggested the creation of an advisory committee to regulate HMOs, which would entail evaluating consumer and provider complaints, reviewing regulations, and overseeing compliance by HMOs. The advisory committee should be composed of representatives of the HMOs, consumers and providers not affiliated with HMOs, consumers affiliated with HMOs, employers, and local government, as well as members of Congress or the Senate, which will have to legislate the required policies. All these people should be interested in the development of HMOs and aware of the dangers of irresponsible or unscrupulous management of HMOs.

COMMUNITY-BASED HMOs

This discussion is based entirely on the final report on the Pilot HMO Project which

was prepared by Health, Education, and Welfare Specialists Inc. (HEWSPECS) and Intercare Research Foundation Inc. (IRFI) (1990).

INTRODUCTION

The community-based HMOs in San Antonio, Biñan, and the University of the Philippines, Diliman, were established by four organizations, namely, the Philippine Council for Health Research and Development (PCHRD), USAID, HEWSPECS, and IRFI. The study that led to the establishment of the HMOs was entitled "Pilot-Testing of the HMO as a Health Financing Scheme." It was an experiment to determine whether prepaid managed health care could generate new financial resources for health at the community level, to provide middle- and low-income families with better access to health care.

Two types of communities were chosen for the experiment. One was a corporate community (UP) which had no health benefits beyond the compulsory health insurance provided by Medicare, and the other was a regular community (San Antonio, Biñan, Laguna) served by private fee-for-service providers and government facilities. These two met the conditions deemed necessary for the success of the project. They had access to a wide range of health facilities but most of their populations could not afford these facilities. More importantly, both the community members and the providers expressed their willingness to participate in the experiment. The HMO alternative was deemed more sustainable than charity care and the consumers felt that participation in the HMO would ease the anxiety of not being able to pay for medical services when they needed them.

The community HMOs are run like investor-based HMOs. The members are required to pay a monthly premium in exchange for a comprehensive health-benefit package which includes preventive care and early detection of diseases, as well as in-patient care. The main difference from profit-oriented, investor-based HMOs is that an external group organized these community HMOs and provided financial

and technical assistance in management and marketing especially in the first few years. The financial and technical assistance would be withdrawn once the HMO had grown and membership and use had stabilized. It was expected that members of the community could be trained to manage the HMO and that the HMO would become viable as enrolment exceeded the minimum.

Another difference is that the community HMOs provide much lower benefits than those marketed by investor-based HMOs.

SAN ANTONIO, BIÑAN, HMO (SAHMO)

The SAHMO's primary medical service unit (PMSU) started operating in September 1988 with 134 paying members. In the first year of operations, the HMO encountered difficulties on account of some unscrupulous members. It was reorganized in 1989. With improved services and more systematic and careful recruitment of members and collection of premiums, the membership grew to 400 by 1990. As the HMO gained credibility, retention rates also increased, and there is optimism that the membership will grow even more in the coming years.

The SAHMO was successful in recruiting low-income households, many of whose members reported monthly incomes below 2,000. Not surprisingly, two-thirds of the members chose Plan A, the lowest-cost plan of the HMO which offered only ward accommodations in case of hospitalization. The HMO accredited only one hospital, the Perpetual Help Medical Center in Biñan, Laguna.

UPHMO

The UPHMO started operating in January 1989, four months after SAHMO, with only 89 members. But this HMO accredited six hospitals. Membership grew slowly in the first year—there were 122 members in November 1989—but picked up starting December 1989, so that by June 1990, there were 429 members.

Though it started with fewer members,

the UPHMO is more stable than the SAHMO. It has had very high retention rates and very good credibility. As with the SAHMO, a majority (62%) chose Plan A, but ward, semi-private, and private hospital accommodations are more evenly distributed in the UPHMO, whose members have slightly higher incomes than SAHMO members. The UPHMO is also in a better financial position than the SAHMO, although, at the time of this report, both of them still had financial deficits.

OVERALL CONCLUSIONS

Before the establishment of the pilot HMOs, a community survey was held in both target areas to determine consultation and hospitalization rates (indicators of the accessibility of health care) and the corresponding costs (indicators of affordability). These indicators were compared with the rates and costs of consultation and hospitalization in the pilot HMOs.

Consultations in the pilot HMOs and hospitalization in UPHMO were markedly more frequent than in the community survey. In the SAHMO, on the other hand, the hospitalization rate of HMO enrollees was slightly lower than in the survey. The study revealed that more consultations were made for routine checkups. Also, the hospitalization cases in the HMOs were significantly different from those in the community survey and the length of confinement was markedly shorter, especially in the SAHMO where the period of confinement was only 2.13 days, versus a community average of seven days. (In the UPHMO, the decrease was smaller, from the community average of 5.29 days to 3.4 days.)

In the UPHMO, there was a greater use of public hospitals and cheaper room accommodations than before. In Bifan, where the only other option was a private hospital, the members urged the HMO to accredit public hospitals as well. The study credited this cost-consciousness among the HMO members to the educational campaign waged by the HMOs.

Consultation costs went up in Bifan, from P44 to P54; in UP, they decreased from P148 to P85. Hospitalization costs dropped, from P3,547 to P1,466 in the Bifan HMO (on account of cost savings in room and board charges) and from P3,001 to P1,016 in the UPHMO (on account of savings in professional fees and in drugs and medicines).

The observation period was too short for any definite conclusions to be made about the potential of community-based HMOs. The study concluded, though, that professional management is crucial to the success of HMOs because of the complexity of their operations. Moreover, with the pullout of the external agencies that set up the HMOs and saw them through the early years, sustainability is another key concern.

Other insights gained from the pilot HMO projects were:

- **Nonspontaneous development.** HMOs do not develop spontaneously in communities. People are generally reluctant to put their money into an unknown and untried organization, and so the breakeven level of enrolment is difficult to achieve. For the HMO to take off, it needs support from an external institution like the government, international agencies, or nongovernment organizations.
- **Limited replicability.** Community-based HMOs may not be appropriate in areas where people do not have regular incomes or where there are no health providers. Besides, other areas may not have the level of sophistication needed to organize, run, and manage an HMO.

EMPLOYER-INITIATED HMOs

This discussion is based entirely on "Prepaid Managed Health Care: The Emergence of HMOs as Alternative Financing Schemes in the Philippines" by Ma. Concepcion Alfiler (1989).

The Philippine Airlines (PAL) started its PAL Dependents Medical Plan (PDMP) for the dependents of all its regular employees. The plan first covered Metro Manila employees in February 1988 and was gradually extended to PAL employees in other areas.

Under the program, an employee can enrol two dependents. The employee and PAL share equally in the P85 premium per enrollee. The membership card gives the enrollee access to PAL's medical clinic, which is operated like an MSU of an investor-based HMO. The medical clinic is staffed with four doctors and two full-time nurses and is open 24 hours. Aside from preventive and out-patient care, the PDMP also covers hospital accommodations (not exceeding P250 per day), a 80% refund for in-patient care in a nonaccredited hospital, and payment of up to P50,000 for dread disease.

Unlike investor-based HMOs, the PDMP is nonprofit and serves a well-defined and limited population, membership fees are subsidized by PAL, and premium rates are lower than the rates charged by investor-based HMOs. Otherwise, the PDMP's operations and benefit package are very similar to those of investor-based HMOs.

POTENTIAL AND ROLE OF HMOs IN HEALTH CARE FINANCING

The growth in the total enrolment of HMOs, from about 375,500 in 1989 to 500,000-600,000 in 1990, is impressive, coming as it did despite an economy in distress and in the absence of government incentives. Whether the HMOs grew at the expense of indemnity commercial insurance or because employers provided wider health benefits to their employees, has not been ascertained yet.

However, despite the increase in enrolment, the HMOs' total estimated enrolment in 1990 represents less than 1% of the total Philippine population. Even

with the optimistic growth projections, the number of HMO enrollees is not likely to increase substantially in the next five years, certainly not to the levels covered by Medicare or ECC.

Like indemnity private health insurance, HMOs tend to favor the employed, who can afford to pay the premiums, to focus on group (rather than individual) accounts, and to exclude the elderly. In avoiding risk, HMOs withhold coverage from some portions of the population. Health policy makers must consider this in setting health-financing policies.

It may be appropriate to assess the effects and potential of HMOs, indemnity health insurance, and social insurance in containing health-care costs, improving the quality of medical services, making health services available in the rural areas, and equalizing the distribution of medical manpower and facilities.

Even in the most developed countries, HMOs have not been successful in covering the poor and in providing services in rural and other areas where health providers are unevenly distributed.

AREAS FOR FURTHER STUDY

CONSULTATIONS REGARDING HMO REGULATION

While legislation will have to come from Congress, which should therefore be the venue for discussions, the DOH can assist in the process by initiating consultations outside Congress.

PILOT-TESTING OF HMO SCHEMES FOR THE POOR

As in other countries, HMOs in the Philippines do not serve the poor. We have presented ideas on how this limitation may be dealt with. Some of these ideas can be considered for pilot-testing.

RELATIVE VALUE SCALE (RVS)

PMCC, ECC, and the HMOs all use RVSs in computing doctors' compensation, but they do not use or recognize a common RVS. It may therefore be worthwhile for the DOH to support the updating of the PMCC RVS, which can then be the official RVS to be recognized and followed by all health-care financing institutions in the country. A common RVS will facilitate administration, especially by doctors, and can help contain professional fees.

The effort will be focused on the development of the RVS units, for both surgical and nonsurgical cases. The peso value per unit will be left to the institutions that will use the RVS scale.

Since it has had experience in determining an RVS and plans to update its 1988 RVS, the Philippine College of Surgeons (PCS) could take the lead in the RVS updating. Other organizations, like the Philippine Medical Association, HMOs, other medical specialty societies, PMCC, and ECC, will be consulted to ensure that their inputs are considered.

If possible, the RVS development should be institutionalized, to facilitate periodic review and updating in response to changes in the medical practice.

LINKAGE OF HMOs AND DOH PUBLIC HEALTH PROGRAMS

As has been mentioned, there are clear opportunities where DOH and HMO activities may be linked. Immunization, family planning, oral rehydration therapy, tuberculosis control, and AIDS control are some specific areas where joint logistics, information/education campaigns, and training programs may be explored.

SPECIAL STUDIES

To assist in policy making and to guide HMO operations, a study on the impact of HMOs in containing the cost of health services and in the provision of quality care may be considered.

POSSIBLE HMO PROJECTS

Some projects that can be carried out to assist HMOs are:

- Establishment of a training course for HMO managers and staff. This was begun with the sending of Oscar Lagman to the U.S. for a special course. The HMO training course developed by Mr. Lagman should be implemented.
- Establishment of a data base containing utilization, cost, and other relevant data on individual HMOs. The data should be collated and processed in a preset format so that individual HMOs can compare their performance with that of the industry and find out their strengths and weaknesses. In this regard, it is necessary to identify an institution acceptable to the HMOs which can undertake the activity on a continuing basis. The choice of institution is important because of the confidentiality of HMO data.

COMMERCIAL INDEMNITY HEALTH INSURANCE

INTRODUCTION

An insurance policy is a contract between the insurance company and the insured, in which the latter pays a specified premium in return for a guarantee that the former will pay a specified benefit payment if the insured loss occurs. In health insurance, benefit payments are made to the insured to cover medical expenses he incurs as a result of sickness or injury.

Health insurance is of two types: medical expense coverage, in which the insurance company reimburses the medical expenses of the health provider or the insured or both; and disability income coverage, which compensates the insured for a disability which reduces drastically his ability to earn income by paying him a certain income benefit (Long and Morton 1988).

A loss is insurable if it occurs by chance, is definite and significant in extent, has a predictable rate (using the law of large numbers), and is not catastrophic to the insurer (Long and Morton 1988). Medical

expenses due to sickness or injury are therefore insurable since people generally cannot predict when they will get sick. The above characteristics also explain why in-patient hospital care, including surgical expenses, are insured more than relatively cheaper medical expenses such as dental care, physical checkups, and out-patient care.

When the loss is small and frequent, the administrative cost of the insurance would only raise the premium to uneconomical levels. On the other hand, economic theory shows that people prefer to incur certain small losses in the form of premium payments than to face the uncertain chance of incurring a significant loss (Feldstein 1988).

HEALTH AND ACCIDENT INSURANCE COMPANIES

Table 30 shows that there were 102 health and accident insurance (HAAI)

companies in 1988. Between 1975 and 1988, except for 1981 and 1985, there were from 95 to 107 companies. Following the withdrawal of the only two foreign life insurance companies in 1976, there were no such companies in the business up to 1988.

Table 30 contains a possible instance of underreporting or clerical error. It states that there were six domestic nonlife insurance companies in 1981, whereas other reports before and after 1981 list no fewer than 60 companies. Table 31 supports this observation: the gross premiums for 1981 (P76.5 million) were higher than the previous year's (P63.7 million). If Table 30 were to be taken as accurate, all the clients of the 81 domestic nonlife companies in 1980 transferred to the six insurance companies listed in 1981—a highly improbable event. Also according to Table 30, there were only three domestic life insurance companies in 1981, when there were at least six before and after that year.

Table 30 also reveals the following:

Table 30 Number of Companies Involved in Health and Accident Insurance, 1975-88

Year	Life						Nonlife						Grand Total
	Domestic		Foreign		Total		Domestic		Foreign		Total		
	No.	%	No.	%	No.	% of Grand Total	No.	%	No.	%	No.	% of Grand Total	
1975	7	6.54	2	1.87	9	8.41	83	77.57	15	14.02	98	91.59	107
1976	6	6.32	0	0.00	6	6.32	76	80.00	13	13.68	89	93.68	95
1977	7	6.67	0	0.00	7	6.67	85	80.95	13	12.38	98	93.33	105
1978	7	6.60	0	0.00	7	6.60	86	81.13	13	12.26	99	93.40	106
1979	7	7.37	0	0.00	7	7.37	76	80.00	12	12.63	88	92.63	95
1980	7	6.93	0	0.00	7	6.93	81	80.20	13	12.87	94	93.07	101
1981	3	14.29	0	0.00	3	14.29	6	28.57	12	57.14	18	85.71	21
1982	7	7.14	0	0.00	7	7.14	78	79.59	13	13.27	91	92.86	98
1983	7	7.14	0	0.00	7	7.14	78	79.59	13	13.27	91	92.86	98
1984	6	6.12	0	0.00	6	6.12	79	80.61	13	13.27	92	93.88	98
1985	7	8.97	0	0.00	7	8.97	60	76.92	11	14.10	71	91.03	78
1986	8	7.69	0	0.00	8	7.69	83	79.81	13	12.50	96	92.31	104
1987	10	9.52	0	0.00	10	9.52	84	80.00	11	10.48	95	90.48	105
1988	6	5.88	0	0.00	6	5.88	86	84.31	10	9.80	96	94.12	102
Average	7.66				7.79		76.38		15.83		92.21		

Source: 1975-87: CRC Philippine Health Care Factbook 1990; 1988: Insurance Commission Annual Report 1989

Table 31 Gross Premiums Taken by Health Insurance Companies, 1974-88
(In Thousand Pesos)

Year	Life Insurance										Nonlife Insurance						Grand Total		
	By Location				By Type				Total Life		Domestic		Foreign		Total Nonlife				
	Domestic		Foreign		Ordinary		Group				Amount	% Change	Amount	% Change	Amount	% Change	Amount	% Change	
	Amount	% Change	Amount	% Change	Amount	% Change	Amount	% Change	Amount	% Change	Amount	% Change	Amount	% Change	Amount	% Change			
1974	15,693		818		9,815		6,696		16,511		16,867		5,308		22,175		38,686		
1975	19,183	22.24	87	-89.36	10,670	8.71	8,600	28.43	19,270	16.71	23,602	39.93	14,031	164.34	37,633	69.71	56,903	47.00	
1976	22,667	18.16	0	-100.00	12,403	16.24	10,264	19.35	22,667	17.63	22,906	-2.95	17,038	21.43	39,944	6.14	62,611	10.00	
1977	29,727	31.15	0		13,690	10.38	16,037	56.25	29,727	31.15	28,516	24.49	20,049	17.67	48,565	21.58	78,292	25.00	
1978	35,890	20.73	0		15,547	13.56	20,343	26.85	35,890	20.73	39,893	39.60	21,926	9.36	61,819	27.29	97,709	24.80	
1979	41,940	16.86	0		17,580	13.08	24,360	19.75	41,940	16.86	42,271	18.49	23,251	6.04	70,522	14.08	112,462	15.10	
1980	50,271	19.86	0		19,398	10.34	30,873	26.74	50,271	19.86	63,780	34.92	26,132	12.39	89,912	27.49	140,183	24.60	
1981	58,517	16.40	0		20,869	7.58	37,648	21.94	58,517	16.40	76,501	19.95	33,317	27.50	109,818	22.14	168,335	20.00	
1982	72,952	24.67	0		27,342	31.02	45,610	21.15	72,952	24.67	82,408	7.72	39,815	19.50	122,223	11.30	195,175	15.90	
1983	79,486	8.96	0		24,149	-11.68	55,337	21.33	79,486	8.96	99,875	21.20	45,717	14.82	145,592	19.12	225,078	15.30	
1984	71,253	-10.36	0		27,426	13.57	43,827	-20.80	71,253	-10.36	128,619	28.78	54,121	18.38	182,740	23.52	253,993	12.80	
1985	118,164	65.84	0		30,762	12.16	87,402	99.43	118,164	65.84	164,928	28.23	60,235	11.30	225,163	23.21	343,327	35.17	
1986	146,011	23.57	0		37,582	22.17	108,429	24.06	146,011	23.57	182,294	10.53	66,710	10.75	249,004	10.59	395,015	15.00	
1987	181,216	24.11	0		42,700	13.62	138,516	27.75	181,216	24.11	168,825	-7.39	75,275	12.84	244,100	-1.97	425,316	7.67	
1988	204,960	13.10	0		58,534	37.08	146,426	5.71	204,960	13.10	180,676	7.02	82,934	10.17	263,610	7.99	468,570	10.17	
Average		21.09		-94.68		14.13		26.99		20.66		19.34		25.46		20.30		19.93	

Source: 1974-87: CRC Philippine Health Care Factbook 1990; 1988: Insurance Commission Annual Report 1989

- Between 1975 and 1988, there were more nonlife (92% of the total) than life insurance companies in HAAI.
- Domestic nonlife companies were most active in HAAI (76%), followed by foreign nonlife (15%) and domestic life companies (7%).
- Foreign insurance companies (life and nonlife) represent less than one-fifth of all firms in the business.

GROSS PREMIUMS EARNED BY HEALTH INSURANCE COMPANIES

Gross premiums are all the premiums collected from individuals, families, and groups covered by health insurance contracts.

From Table 31, the following may be seen:

- Total gross premiums for the industry reached about P469 million in 1988.

- Taken together, life and nonlife companies increased an average of about 20% yearly between 1974 and 1988.
- In absolute amounts, nonlife companies had total gross premiums of P263 million in 1988, compared to the P205 million of life companies.

This comparative performance is noteworthy, considering that in 1988, there were 96 nonlife companies and only six domestic life companies in HAAI (Table 30). The inference is that each nonlife company was earning an average of P2.74 million in premiums, while each domestic life company was earning about P34.2 million.

- In 1988, the ten foreign nonlife companies generated gross premiums of P82.9 million, or around P8.3 million per company. In contrast, the 86 domestic nonlife companies earned about P181 million, or P2.1 million each.

It appears, therefore, that domestic life insurance companies sell the most health insurance per company (P34.2 million in 1988), followed by foreign

nonlife companies (P8.3 million) and domestic nonlife companies (P2.1 million).

- Foreign nonlife companies showed the highest average growth rates between 1974 and 1978 (25%), followed by domestic life (21%) and domestic nonlife companies (19%).
- In 1988, life companies earned about P146 million in group health insurance premiums, or about 2.5 times the P58.5 million for ordinary insurance, including sales to individuals and families. Moreover, group insurance grew faster, at an annual average rate of 27%, than ordinary HAAI (14%) between 1974 and 1988.

As will be discussed below, the conscious effort of life insurance companies to focus on group accounts explains this dominant role of group health insurance.

Table 32 indicates the following:

- Of total premiums earned between 1974 and 1988, about 63% went to nonlife

Table 32 Percentage of Gross Premiums Taken by Health Insurance Companies, 1974-88
(In Thousand Pesos)

Year	Life Insurance										Nonlife Insurance						Grand Total Amount		
	By Location					By Type					Total Life		Domestic		Foreign			Total Nonlife	
	Domestic		Foreign			Ordinary		Group			Amount	%	Amount	%	Amount	%		Amount	%
	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%		Amount	%
1974	15,693	40.57	818	2.11	9,815	25.37	6,696	17.31	16,511	42.68	16,867	43.60	5,308	13.72	22,175	57.32	38,686		
1975	19,183	33.71	87	0.15	10,670	18.75	8,600	15.11	19,270	33.86	23,602	41.48	14,031	24.66	37,633	66.14	56,903		
1976	22,667	36.20	0	0.00	12,403	19.81	10,264	16.39	22,667	36.20	22,906	36.58	17,038	27.21	39,944	63.80	62,611		
1977	29,727	37.97	0	0.00	13,690	17.49	16,037	20.48	29,727	37.97	28,516	36.42	20,049	25.61	48,565	62.03	78,292		
1978	35,890	36.73	0	0.00	15,547	15.91	20,343	20.82	35,890	36.73	39,893	40.83	21,926	22.44	61,819	63.27	97,709		
1979	41,940	37.29	0	0.00	17,580	15.63	24,360	21.66	41,940	37.29	42,271	42.03	23,251	20.67	70,522	62.71	112,462		
1980	50,271	35.86	0	0.00	19,398	13.84	30,873	22.02	50,271	35.86	63,780	45.50	26,132	18.64	89,912	64.14	140,183		
1981	58,517	34.76	0	0.00	20,869	12.40	37,648	23.36	58,517	34.76	76,501	45.45	33,317	19.79	109,818	65.24	168,335		
1982	72,952	37.38	0	0.00	27,342	14.01	45,610	23.37	72,952	37.38	82,408	42.22	39,815	20.40	122,223	62.62	195,175		
1983	79,486	35.31	0	0.00	24,149	10.73	55,337	24.59	79,486	35.31	99,875	44.37	45,717	20.31	145,592	64.69	225,078		
1984	71,253	28.05	0	0.00	27,426	10.80	43,827	17.26	71,253	28.05	128,619	50.64	54,121	21.31	182,740	71.95	253,993		
1985	118,164	34.42	0	0.00	30,762	8.96	87,402	25.45	118,164	34.42	164,928	48.04	60,235	17.54	225,163	65.58	343,327		
1986	146,011	36.96	0	0.00	37,582	9.51	108,429	27.45	146,011	36.96	182,294	46.15	66,710	16.89	249,004	63.04	395,015		
1987	181,216	42.61	0	0.00	42,700	10.04	138,516	32.57	181,216	42.61	168,825	39.69	75,275	17.70	244,100	57.39	425,316		
1988	204,960	43.74	0	0.00	58,534	12.49	146,426	31.25	204,960	43.74	180,676	38.56	82,934	17.70	263,610	56.26	468,570		
Average		35.77		0.15		14.38		22.54		36.92		47.77		20.31		63.08			

Source: 1974-87: CRC Philippine Health Care Factbook 1990; 1988: Insurance Commission Annual Report 1989

insurance companies and 37% to life companies. This proportion was maintained throughout the period, although the share of nonlife companies declined perceptibly, to about 57%, in 1987 and 1988.

- From 1974 to 1988, domestic life and nonlife companies dominated the industry, averaging 79% of gross premiums (36% for life and 43% for nonlife companies).

GROSS RISKS TAKEN BY HEALTH INSURANCE COMPANIES

Gross risks are the total face value of the health insurance policies issued by insurance companies, or the total potential benefit payments contracted by the insurance companies with their insured clients.

For lack of data, this analysis covers only gross risks of nonlife companies.

According to Table 33:

- In 1988, nonlife companies had gross risks of ₱125.7 billion. Of this amount,

Table 33 Gross Risks Taken by Nonlife Health Insurance Companies, 1974-88
(In Thousand Pesos): Breakdown by Location

Year	Domestic		Foreign		Total Amount
	Amount	% of Total	Amount	% of Total	
1974	17,594,256	82.48	3,737,653	17.52	21,331,909
1975	20,814,509	88.22	2,780,177	11.78	23,594,686
1976	7,436,902	61.18	4,718,183	38.82	12,155,085
1977	27,830,355	83.95	5,320,273	16.05	33,150,628
1978	24,878,571	67.99	11,711,169	32.01	36,589,740
1979	29,159,137	93.61	1,990,259	6.39	31,149,396
1980	52,974,417	77.97	14,965,328	22.03	67,939,745
1981	56,280,308	75.00	18,759,975	25.00	75,040,283
1982	40,140,915	72.77	15,023,188	27.23	55,164,103
1983	48,818,154	89.25	5,879,794	10.75	54,697,948
1984	63,231,382	81.48	14,371,093	18.52	77,602,475
1985	65,036,310	80.72	15,529,589	19.28	80,565,899
1986	61,655,095	82.89	12,724,133	17.11	74,379,228
1987	64,745,899	58.31	46,284,025	41.69	111,029,924
1988	78,256,876	62.21	47,528,165	37.79	125,785,041
Average		76.83		23.17	

Source: 1974-87: CRC Philippine Health Care Factbook 1990; 1988: Insurance Commission Annual Report 1989

₱78.2 billion (62%) was borne by domestic companies and the balance of ₱47.5 (38%) by foreign companies. Relating the gross risks of nonlife companies to their gross premiums in 1988, each ₱1 of premium carried a

₱476 risk (₱125.8 billion/₱264 million).

- Between 1974 and 1988, the average share of domestic and foreign nonlife companies in total risks was 77% and 23%, respectively. This proportion

stands to reason since domestic nonlife companies accounted for about 67% of total nonlife gross premiums for the same period.

We note the following, from Table 34:

- Gross risks of nonlife companies grew at an average rate of about 24% between 1974 and 1988, compared to the 20% rise in gross premiums (Table 31). In 1987 and 1988, while gross premiums of nonlife companies grew by about -2% and 8%, respectively, gross risks surged by 49% and 13%. In fact, the annual rates of change in gross premiums (column 17 of Table 31) and gross risks (last column of Table 34) show no correlation between the premium charged and the risks taken.

This is contrary to expectations that the higher the contracted benefit payment, the higher the premium charged. A possible explanation for the noncorrelation (assuming accuracy of data) is that insurance companies hope to make their policies more attractive by increasing the benefit limits beyond those covered by actuarially computed

premiums. This strategy suits group accounts, where the risks can be distributed over a larger population and where experience rating may be utilized.

- No trends can be seen in the annual growth of gross risks of domestic and foreign insurance companies. Gross risks and gross premiums, when compared year by year, also show no correlation.

LOSSES TAKEN BY HEALTH INSURANCE COMPANIES

Losses refer to the benefits paid by insurance companies.

Table 35 (page 51) shows the following:

- In 1988, the industry had total losses of about P237 million, or about 51% of gross premiums collected, or P0.51 for every P1 of premium earned.
- Oddly enough, domestic life insurance companies reported no losses from ordinary or group accounts for 1980 and

1983. This means that there was not a single claim for reimbursement of medical expenses among those who paid gross premiums of P50.3 million and P79.5 million in those years—a highly unlikely event. Perhaps no reports were submitted for the two years. If so, the limitation would qualify all analyses of averages in this section.

- Losses of life insurance companies represented 41% of the industry total, between 1974 and 1988.

REAL GROWTH RATES OF GROSS PREMIUMS AND LOSSES

Table 36 (page 51) presents the total gross premiums and losses in nominal and real terms, using the price index for medical services. The real gross premiums indicate the number of persons covered and policies issued by private health insurance companies, on which no data are available. The nominal increase in gross premiums does not necessarily mean more people covered by insurance. It could mean that the same people are paying higher premiums because of costlier medical care.

From the table, we can see that real premiums have also been increasing through time, but much more slowly than the nominal growth rate. This is even more obvious in Figure 6, where the line representing real gross premiums is almost flat. The same observation is true for total losses, where the real growth rate is considerably lower than the nominal rate.

Table 34 Gross Risks Taken by Nonlife Health Insurance Companies, 1974-88 (In Thousand Pesos): Growth Analysis

Year	Domestic		Foreign		Total	
	Amount	% Change	Amount	% Change	Amount	% Change
1974	17,594,256		3,737,653		21,331,909	
1975	20,814,509	18.30	2,780,177	-25.62	23,594,686	10.61
1976	7,436,902	-64.27	4,718,183	69.71	12,155,085	-48.48
1977	27,830,355	274.22	5,320,273	12.76	33,150,628	172.73
1978	24,878,571	-10.61	11,711,169	120.12	36,589,740	10.37
1979	29,159,137	17.21	1,990,259	-83.01	31,149,396	-14.87
1980	52,974,417	81.67	14,965,328	651.93	67,939,745	118.11
1981	56,280,308	6.24	18,759,975	25.36	75,040,283	10.45
1982	40,140,915	-28.68	15,023,188	-19.92	55,164,103	-26.49
1983	48,818,154	21.62	5,879,794	-60.86	54,697,948	-0.85
1984	63,231,382	29.52	14,371,093	144.41	77,602,475	41.87
1985	65,036,310	2.85	15,529,589	8.06	80,565,899	3.82
1986	61,655,095	-5.20	12,724,133	-18.07	74,379,228	-7.68
1987	64,745,899	5.01	46,284,025	263.75	111,029,924	49.28
1988	78,256,876	20.87	47,528,165	2.69	125,785,041	13.29
Average		26.34		77.95		23.73

Source: 1984-87: CRC Philippine Health Care Factbook 1990; 1988: Insurance Commission Annual Report 1989

Fig. 6 Nominal and Real Gross Premiums and Losses

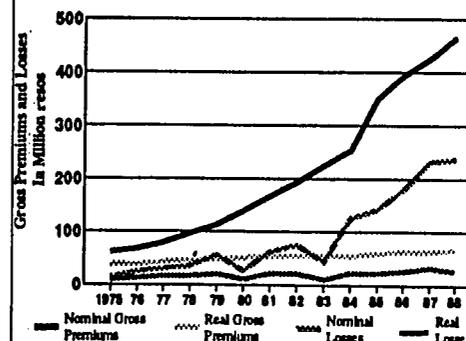


Table 35 Losses Taken by Health Insurance Companies, 1974-88
(In Thousand Pesos)

Year	Life								Total Life		Nonlife				Total Nonlife		Grand Total (Life and Nonlife) Amount
	By Location				By Type						Domestic		Foreign				
	Domestic		Foreign		Ordinary		Group		Amount	%	Amount	%	Amount	%			
	Amount	%	Amount	%	Amount	%	Amount	%									
1974	5,314	41.46	543	4.24	167	1.30	5,690	44.40	5,857	45.70	4,915	38.58	2,014	15.71	6,959	54.30	12,816
1975	2,591	22.68	0	0.00	2,203	19.27	391	3.42	2,594	22.68	4,210	36.82	4,631	40.50	8,841	77.32	11,435
1976	9,001	41.46	0	0.00	0	0.00	9,001	41.48	9,001	41.48	7,387	34.04	5,312	24.48	12,699	58.52	21,700
1977	13,030	44.48	0	0.00	7,679	26.22	5,351	18.27	13,030	44.48	7,554	25.79	8,707	29.73	16,261	55.52	29,291
1978	16,034	49.22	0	0.00	9,610	29.50	6,424	19.72	16,034	49.22	8,836	27.12	7,707	23.66	16,543	50.78	32,577
1979	19,672	39.95	0	0.00	10,677	21.68	8,995	18.27	19,672	39.95	20,712	42.06	8,858	17.99	29,570	60.05	49,242
1980	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	18,785	70.90	7,711	29.10	26,496	100.00	26,495
1981	31,958	52.83	0	0.00	0	0.00	31,958	52.83	31,958	52.83	18,344	30.33	10,188	16.84	28,532	47.17	60,490
1982	40,096	54.44	0	0.00	0	0.00	40,096	54.44	40,096	54.44	21,863	29.69	11,687	15.87	33,550	45.56	73,646
1983	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	28,167	62.16	17,148	37.84	45,315	100.00	45,315
1984	64,393	50.07	0	0.00	61,457	47.79	2,936	2.28	64,393	50.07	47,293	36.77	16,915	13.15	64,208	49.93	128,601
1985	83,624	57.44	0	0.00	0	0.00	83,624	57.44	83,624	57.44	36,133	24.82	25,830	17.74	61,963	42.56	145,587
1986	101,193	54.27	0	0.00	65,735	35.25	35,458	19.02	101,193	54.27	51,415	27.57	33,862	18.16	65,277	45.73	186,470
1987	130,612	55.65	0	0.00	4,234	1.80	126,378	53.85	130,612	55.65	63,323	26.98	40,755	17.37	104,078	44.35	234,690
1988	112,727	47.60	0	0.00	0	0.00	112,727	47.60	112,727	47.60	87,093	36.77	37,008	15.63	124,101	52.40	236,828
Average	42,017	40.72	36	0.00	10,784	12.96	31,269	27.76	42,053	40.72	28,404	36.56	15,869	22.72	44,293	59.28	86,346

Source: 1984-87: CRC Philippine Health Care Factbook 1990;
1988: Insurance Commission Annual Report 1989

Table 36 Total Gross Premiums and Losses, in Nominal and Real Terms
(In Thousand Pesos; 1972=100)

Year	Price Index for Medical Services	Gross Premiums		Losses	
		Nominal	Real	Nominal	Real
1975	155.5	56,903	36,594	11,435	7,354
1976	177.9	62,611	35,194	21,700	12,198
1977	195.9	78,292	39,965	29,291	14,952
1978	218.2	97,709	44,780	32,577	14,930
1979	252.0	112,462	44,628	49,242	19,540
1980	296.7	140,183	47,247	26,496	8,930
1981	337.8	168,335	49,833	60,490	17,907
1982	384.6	195,175	50,748	73,646	19,149
1983	432.6	225,078	52,029	45,315	10,475
1984	550.8	253,993	46,113	128,601	23,348
1985	648.5	343,327	52,942	145,587	22,450
1986	695.5	395,015	56,796	186,470	26,811
1987	737.6	425,316	57,662	234,690	31,818
1988	781.3	468,570	59,973	236,828	30,312

Source: CRC Philippine Health Care Factbook 1990

There is therefore reason to believe that the indemnity health insurance industry in the Philippines is growing very slowly, if at all, in terms of people covered. Premium growth is due basically to the higher cost of health services, which insurance companies

translate into higher premiums. This contention is supported by the fact that the number of companies in HAAI did not grow in the period under consideration (Table 37, page 52), implying that the industry is not attractive to potential investors.

CONSTRAINTS ON INDIVIDUAL FIRMS

The life insurance companies interviewed for this study do not find commercial HAAI an attractive product line. They market health insurance as a "sweetener," to complement the life insurance packages they offer or to complete their array of insurance products.

Health insurance is deemed unprofitable. An industry source indicated that HAAI offers a profit of 2% of premium at best, compared to at least 10% of premium for life insurance.

Our analysis revealed industry losses to be only about 51% of premiums in 1988. Also, as Table 36 shows, premium collection has always exceeded losses, in both nominal and real terms. Hence, the unprofitability of health insurance may be due to marketing and administrative costs.

The profitability issue, on top of low incomes, could be a major reason for the sluggish growth of health insurance.

Where health insurance is sold, group

Table 37 Number of Companies Involved in Health and Accident Insurance, 1975-88

Year	Life			Nonlife			Grand Total (Life and Nonlife)
	Domestic	Foreign	Total	Domestic	Foreign	Total	
1975	7	2	9	83	15	98	107
1976	6	0	6	76	13	89	95
1977	7	0	7	85	13	98	105
1978	7	0	7	86	13	99	106
1979	7	0	7	76	12	88	95
1980	7	0	7	81	13	94	101
1981	3	0	3	6	12	18	21
1982	7	0	7	78	13	91	98
1983	7	0	7	78	13	91	98
1984	6	0	6	79	13	92	98
1985	7	0	7	60	11	71	78
1986	9	0	8	83	13	96	104
1987	10	0	10	84	11	95	105
1988	6	0	6	86	10	96	102

Source: 1974-87: CRC Philippine Health Care Factbook 1990;
1988: Insurance Commission Annual Report 1989

enrolment is preferred over individual applications (Table 31), which carry greater actuarial risk and represent greater potential losses for the insurance company. People over 60 are excluded because of the risk involved. Generally, individual health insurance is offered merely as a "rider" to life insurance.

Industry sources cited the following operating constraints:

- **Keen competition**, partly on account of insurance brokers who negotiate the best premium for their clients.
- **Pricing problems**, which arise when the cost of medical care increases substantially during the year. Premium rates are set at the start of the year or before the contract period, and the insurance company must seek clearance from the Insurance Commission before it can increase premiums.
- **Hospitalization incentives**. People with health insurance are observed to avail of health services more freely, affecting the profitability of insurance companies.
- **High administrative costs**. Updating the enrollee list and processing claims entail high administrative costs,

especially for the insurance company selling different plans or benefit packages.

Sources also mentioned the following issues faced by the industry as a whole:

- **Regulation**. As mentioned previously, insurance companies cannot react immediately to higher health-care costs but have to wait for clearance from the Insurance Commission before revising their premium rates. The Insurance Commission is perceived as treating health and life insurance in the same way. The following changes in insurance regulations were accordingly suggested:

- The Insurance Code should contain a separate section for health and accident insurance, instead of treating it together with life insurance, with the life insurance provisions predominating. But health insurance and life insurance have basic differences:

- * A life insurance contract does not allow coverage to be terminated as long as the insured pays his premiums on time. It is suggested that this provision be modified to allow health

insurance to be stopped immediately particularly in cases of clear abuse of coverage.

- * Life insurance regulations require that in the payment of all premiums after the first, the insured be given a 30-day grace period from the due date. It is suggested that no such grace period be allowed for health insurance. Otherwise, someone who has decided to end his coverage but falls ill within the 30-day grace period may seek to be reinsured.

- Investments by life insurance and health insurance companies should be treated separately. Health insurance, by its very nature, covers short-term liabilities. Hence, health insurance companies should be allowed to make short-term investments.

- **Taxes**. A 2% tax is suggested instead of the 5% premium tax, which has driven up the cost of insurance coverage.

- **Lack of an association of health insurance companies**, where issues can be discussed and reforms proposed. This lack reflects the minor role of health insurance in the total revenues of life and nonlife companies because of its perceived unprofitability.

INDUSTRY PROSPECTS

The life insurance companies interviewed do not foresee dramatic growth for commercial health and accident insurance because of the generally low incomes and the unprofitability of the product line. They see themselves as focusing on group health insurance and on "hospital cash plans," which do away with claims processing, avoid evaluating claims versus abuse and fraud, are less profitable to those who pad or fake claims, and reduce the risk of antiselection or adverse selection.

An insurance company official interviewed also sees the health insurance market

as veering away from indemnity insurance, which is seen as restrictive because of its inherently limited benefits, and towards comprehensive health plans (such as HMOs). He cited his experience with labor unions, which demand HMO-type benefits, to prove his point. While indemnity insurance offers a wider choice of doctors than the HMOs, he contends that free choice does not make much difference among rank-and-file employees who generally have no family physicians or specialists.

It would therefore seem that while HAAI meets the health financing needs of some sectors of the population, it does not yet play a significant role in health financing in the country, particularly in expanding coverage to more people.

Moreover, there are disturbing signs that a disadvantage of health insurance about which Reinhardt warned is appearing in the Philippines: the segmentation of the population, with

insurance companies cutting their risks by covering groups and people below 60 years. Moreover, group coverage means greater attention to the employed sector. For an individual, therefore, his insurance coverage is connected to his employment. If he loses his job, he also loses his company-provided benefits and his social insurance, at a time when he is most financially vulnerable. Health policy makers must deal with this issue (Reinhardt 1991).

EMPLOYER-PROVIDED HEALTH BENEFITS

Employer-provided health benefits can be legally mandated, can result from collective bargaining agreements, or can be granted voluntarily by the company. These benefits include, among others: in-patient and out-patient health services, hospital loans, medical insurance, maternity benefits, and medical savings fund (Intercare 1987).

LEGALLY MANDATED BENEFITS

Apart from Medicare and ECC, which were discussed previously, there are other legally mandated health benefits.

Book Four, Title I of the Labor Code specifies the following minimum medical, dental, and occupational safety obligations of employers:

- First-aid treatment (Art. 156) - requiring the availability of first-aid medicines, equipment, and trained employees within the establishment.
- Emergency medical and dental services (Art. 157) - free medical and dental facilities and services for company employees, depending in extent on the size of the work force and on work hazards, as follows:
 - more than 50 but not more than 200 employees in a nonhazardous work place: graduate first-aid if no registered nurse is available
 - more than 50 but not more than 200 employees in a hazardous work place: full-time registered nurse
 - more than 200 but not more than 300 employees: full-time registered nurse, part-time physician and dentist, and emergency clinic.

For hazardous work places, the Labor Code mandates that part-time doctors must stay on the company premises at least two hours daily and full-time doctors, at least eight hours. Moreover, the company may enter into an arrangement with an accessible hospital or dental clinic instead of maintaining its own facility.

- Mandatory occupational safety and health standards, as determined by the secretary of labor and employment.

HEALTH BENEFITS IN COLLECTIVE BARGAINING AGREEMENTS

An Intercare study (1987) showed that of the 42 companies that filed CBAs with

the Department of Labor and Employment in 1985, 55% gave free consultations to employees while 57% extended hospitalization assistance of not more than P1,000 per employee per year. Moreover, 55% of the companies covered employees and their dependents and 83% had a medical fund for employees (Table 38).

In a 1989 survey of collective bargaining agreements of 149 companies by the Personnel Management Association of the Philippines (PMAP), a majority (32%) included group hospitalization insurance contracts with private companies, and 15% listed company-administered medical insurance programs among the benefits (Table 39, page 55). About 11% relied on HMO services, and about 7% provided hospitalization assistance to workers. Although not shown in the table, companies also reported providing dental and maternity services and free medicines. Thirty percent of the companies covered dependents of

Table 38 Company-Financed Health-Related Benefits Embodied in CBAs, 1985

Benefits	No. of Companies Providing Benefits		No. of Companies Not Providing Benefits	
	No.	%	No.	%
Covers employees and dependents	23	54.8	16	38.1
Free consultation	23	54.8	16	38.1
Free medicines with allowable reimbursements	19	45.2	20	47.6
Free dental services	22	52.4	17	40.5
Hospital provision higher than Medicare's	24	57.1	15	35.7
Covers surgical and operation cost	13	30.9	26	61.9
Includes hospital loan	3	7.1	36	85.7
Medical fund for employees	14	33.0	25	59.5
Medical savings fund	0	0.0	39	92.8
Family planning	22	52.4	17	40.5
Retirement	18	42.8	21	50.0
Insurance plan	17	40.5	22	52.4
Memorial plan	5	11.9	34	80.9

Source: Intercare 1987

Table 39 Health Benefits Included in Company CBAs, by Industry, 1989

Industry	No. of Companies Surveyed	Type of Plan				Coverage			Premium Payment		
		Hospital Insurance	Hospital Assistance	HMO	Company Plan	CBA Employees	All Employees	Employees and Dependents	Employer	Subsidy with Limits	Shared
Appliance and Semiconductor	10	5	1			2	4			2	1
Automotive	6	4	1				2	3			2
Banking and Finance	6		1	1		1		2			2
Basic Metals	10	5	2	2			5	2	2	1	3
Computer and Telecom	7	1		1	4		3	4	1	1	3
Consumer Products	7	5					2		2		1
Food and Beverage	10	6	3				2		1	1	6
Garments	14	4					5	2			
Hotels and Restaurants	9	3		5	1		4	5	6	2	
Insurance	8	3			5		5	3			1
Mining and Quarrying	5		1					4			1
Paints and Chemicals	16	4	1	2	1			7		1	4
Pharmaceuticals	21	5		2			2	11		1	1
Print/Media	11	3	1	1	5		9	1	2	3	
Transportation	4			2	2		3	1	3		
Wood	5				4		5				
No. of Companies	149	48	11	16	22	3	51	45	17	12	25
% of Total	100.0	32.2	7.4	10.7	14.8	2.0	34.2	30.2	11.4	8.1	16.8

Source: Personnel Management Association of the Philippines 1989

their employees, but a greater percentage (34%) limited coverage to their employees. Where dependents were covered, employees normally shared in the costs of the premiums. Only a tenth of the employers surveyed paid the full premium.

Table 39 also shows no distinct pattern in employee hospital benefits across industry groups. This may be due to lack of uniformity in reporting.

Although collective bargaining agreements are important vehicles for organized labor to press for greater medical protection through insurance or other means, medical expense protection remains a low priority even among labor organizers, as interviews show. Organized Philippine labor still sees direct pressures for higher wages, monetary or cash benefits, and improved working conditions as more important. The size of the company is a major factor determining the ability of employers to respond to such pressures.

Table 40 Company-Financed Health Benefits, 1990 (n = 127)

Benefits	% of Companies Reporting
Compensation/Benefits	
Maintenance of medical/dental retainer	97
Availment of HMO benefits	79
Health and Safety	
Provision for adequate medical examination	97
Dental services maintenance	93
Maintenance of accurate and complete medical records for each employee	93
Company infirmary/Clinic maintenance	89
Health education and counseling	87
Safety awareness and training	83
Promotion of safety logos and quotes	79
Immunization program	72
Nutrition program	52

Source: Personnel Management Association of the Philippines Research Committee and Andersen Consulting, Human Resource Management: Practices and Issues Survey, 1990

VOLUNTARILY PROVIDED HEALTH BENEFITS

This category includes employers without CBAs but providing health benefits beyond what is legally mandated, because of their corporate social philosophy or consultations with employees.

Table 40 shows the extent of company-financed health benefits based on a 1990 human resource survey by PMAP. Of the 127 companies surveyed, 97% reported providing medical/retainer services and 79% used HMOs. The same table shows that 87% of the respondent companies had infirmaries or clinics on their premises.

POLICY IMPLICATIONS

Employer-provided health benefits, especially those exceeding legal requirements, improve financial access to health services among employees and, in some cases, their dependents.

From a policy standpoint, it may be worthwhile to estimate the extent to which company-provided benefits contribute to the total cost of health services in the country. The research may also include more detailed analyses of benefits by industry sector and geographic area.

Research on the development of employment-based health plans could show the degree of interaction among private insurers, employers, employees (organized

and unorganized), and regulatory agencies. Improvements that will widen coverage and promote more equitable medical protection can be identified.

It would also be interesting to see how companies are dealing with issues like rising health-care costs (through utilization certification and review) and quality of service. Knowledge of the factors that dictate choice of health plan would assist in the development of cost-effective financing mechanisms. Studies on ways of linking DOH public health programs (such as family planning and health education) with company-provided benefits can also be undertaken. The results of such researches can give policy makers better insights into how employer-financed health services can be properly integrated into the country's overall health-care financing policy.

COMMUNITY-LEVEL INSURANCE

INTRODUCTION

Community-level insurance is community health financing with risk-sharing features. Community health financing refers to a community's mobilization of resources to support—whether fully or partially—preventive, curative, promotive, or rehabilitative services for its members (Alfiler 1986).

Community members providing free labor or donating materials for the construction of a health center or giving blood are engaged in community financing. These activities lack the risk-sharing characteristics of insurance. On the other hand, people contributing some amount regularly to a common fund in exchange for discounted medical services or drugs are also engaged in community financing but because they share risks, this community financing may be categorized as community-level insurance.

Community-level insurance, which is generally oriented to the provision of primary health care, is still in its infancy and its financial viability is doubtful (Lewis 1988). Moreover, it has limited ability to generate enough resources to cover the full cost of medical services, and has to be supplemented with external funds (Alfiler 1986).

These observations about community-level insurance in particular and community health financing in general are reinforced by a study of more than 70 community self-financing schemes worldwide made by Stinson. The study concluded that community financing is, at best, only one element in a balanced financing approach. It does not cover supervision, logistics, or referrals, all of which should be funded from other sources for community financing to be effective.

In addition, the following inputs from outside the community are deemed essential: community mobilization; liaison, technical and managerial assistance to individual communities; and back-up resources for temporary deficits (Alfiler 1986).

THE PHILIPPINE EXPERIENCE

The extent to which community-level insurance in particular and community financing in general contribute to overall health care financing in the country has yet to be studied. But such community initiatives abound.

A recent health and management information systems (HAMIS) contest sponsored by the DOH and the German Agency for Technical Cooperation (GTZ) uncovered a rich lode of community-level health insurance activities in the Philippines. The entries were very interesting, for they reflected a variety of innovative schemes all over the country. (See Table 41 for a list of projects and Table 42 on the next page for a summary of the projects' beneficiaries and funding sources.)

Among the noteworthy projects was one initiated by diabetic patients in Lucena City, wherein a fixed monthly contribution by the members entitled them to lower-cost diagnostic services and better-quality care. There was also a Mothers Club for PHC in Surigao City, where mothers paid a monthly membership fee and participated in PHC activities while simultaneously benefitting from discounts at selected grocery stores in the city.

The DOH can set a policy defining the role of community-level financing in the

overall health-care financing strategy of the country. In setting the policy, the DOH must bear in mind the fact that community initiatives grow out of specific community needs and are made possible by specific community capabilities. The DOH policy need not apply to all communities nationwide but can focus initially on activities in areas where the community has been mobilized and an organizational structure already exists.

Table 41 List of HAMIS Contest Entries with Health Insurance Components, 1991

Health Insurance, Diliman and Biñan
PHC for Mental Health, Bulacan
Damayán, Bulacan
Multitarget Development, Bulacan
Three Years Ambassadors, 15 sites
Health Foundation, Iloilo
Hospital Networking, Iligan
Health Banking and Development, Sorsogon
Health Insurance, Lian
Multipurpose Charity, Lucena
Water and PHC, La Union
Nutrition and MCH, Davao
Integrated Development Agency, Pampanga
Drugstore Cooperative, Tondo
University Outreach, Iloilo
Diabetic Patients Association, Lucena
Health and Social Centers, Tondo
Mothers Club for PHC, Surigao
Saving for Health and Development, Lucena
Doctors and Community Health, Cebu
Plan Ahead, Camarines

Note:

The above projects must meet at least two of these three criteria:

- *implies willingness of beneficiaries to participate and share*
- *stimulates risk and cost sharing between sick and healthy*
- *introduces risk sharing*

Source: HAMIS Project, Department of Health

Table 42 HAMIS Contest Entries with Health Insurance Components
Summary of Beneficiaries and Funding Sources

Beneficiaries		
General population groups whole country general public in... residents of... households families Socioeconomic population groups hinterland communities urban poor internal refugees residents of hard-to-reach areas indigents farmers fishermen radio listeners	Demographic population groups women children aged... mothers family dependents family planning couples Patients patients emergency cases patients (by hospital department) third-degree malnourished children TB patients screened persons (without TB) Organizations fishermen's organization community as a whole	Organization members members beneficiary members supportive members active members lifetime members donor members full-fledged members association beneficiaries loan recipients Organization actors health office personnel trained barangay health workers community development workers offices for cooperative

Funding Sources		
Contributions from existing organizations in kind regular DOH supply lot provided for local government materials from private industry free supply of...from... Contributions grant from foreign donor local government funds contribution to PAGCOR city government funds contributions from government agencies PHC funds loan from... Contributions in kind donation of blood voluntary labor	voluntary supply of materials Special fund-raising activities fund raising for specific projects town fiesta proceeds raffles beauty contest popularity contest bingo game Christmas caroling benefit dance cockfighting collection of empty bottles collections paluwagan Income from entrepreneurial activities sale of proceeds from the backyard sale of piglets	sale of fish powder sale of herbal medicines lending of assets patient fees fee for services tuition fees excess of sale over purchases provident fund botica fund interest income... Income from charity benefactors' contributions donations from... voluntary contributions Income from self-organization membership fees cooperative income

For instance, the HAMIS contest showed an abundance of community initiative in providing medicines to members, to help fill the perennial lack in government facilities. The DOH can support such activities by linking the communities to its drug procurement network and herbal manufacturing program.

The DOH can also encourage patients suffering from common chronic diseases (such as heart patients or renal patients) to organize themselves along the lines of the diabetic patients association in Lucena City.

Such DOH initiatives may not apply nationwide, but they answer needs of

specific segments of the population that none of the health insurance mechanisms discussed in this paper answer. Therefore, the DOH should support and encourage community-level health financing programs. To the extent that such initiatives work, they lighten the burden on government resources. NGOs may also be tapped.

CONCLUSION

One way of presenting alternative financing sources for medical services is shown in Table 43. These sources are not mutually exclusive.

The table shows that health insurance has helped make health services financially accessible to more of the employed and to the self-employed but not to all of these nor to the unemployed. Unfortunately, those not covered by insurance, who must depend on inadequate government services and on their own resources, are at the lower economic levels of society.

In the interest of equity, the government must improve and expand health services to these underprivileged sectors. The government can provide the expanded services directly or through private providers, but it must itself grapple with the basic issue of where and how to get the massive resources required.

Health insurance is one way of

generating health funds. Despite its aforementioned limitations, insurance introduces the concept of risk sharing, a notable feature that implies that people must share in the burden of financing their health requirements. Insofar as insurance widens population coverage and increases the support value of its benefits, then the government's work is made easier for it.

Efforts to promote health insurance must be linked to an overall health financing policy, since health insurance, as well as any reforms in it, affects service providers, cost escalation, and availment of medical care, among others.

But since the Philippines is still developing its health financing policy, policy makers must answer the key question: Should health insurance be encouraged pending the formulation of such a policy? If so, how should such an activity be pursued without committing the country to a definite course of action from which it may have to

veer in the future?

To illustrate, doctors in the Philippines are now paid on a fee-for-service basis, with the physician setting the fee according to his assessment of the complexity of the illness and the patient's ability to pay. Even with the entry of HMOs and the use of RVS, a doctor can refuse the fee schedule proposed by the HMO and price his services as high as he wants. Hence, promoting health insurance now without fee reforms will merely reinforce the present practice of compensating doctors. On the other hand, if the health financing policy that is finally adopted turns out to be like the Canadian system and puts a global cap on all professional fees, the task of reform would be made more difficult by present initiatives that are not anchored on an overall policy and approach.

Reinhardt (1990) says that policy makers must be guided as to the priority they should attach to each of the three

Table 43 Summary of Financing Sources for Medical Services

Financing Sources	People Covered			% of Total Philippine Population (1990) Covered	Financing % of Total Health-Care Expenditures (1985)
	Formal Sector	Informal Sector			
	Employed	Self-Employed	Unemployed		
Out-of-Pocket	X	X	X	100	36%
Community Financing	X	X	X	no data	70% <small>(out-of-pocket, community financing, and company-provided)</small>
Company-Provided	X	-	-	no data	
HMOs/Indemnity Insurance	X	X	-	.81-.97 (HMOs only)	1
Social Insurance (Medicare, ECC)	X	X	-	.38	3
Government	X	X	X	100	24
Foreign Assistance					2

Source: Intercare 1987

objectives of a health-care system, namely: equity, freedom of providers in the practice of their profession and the pricing of their services, and economic and budgetary control. Otherwise, Reinhardt admonishes us, reform efforts will be wasted and frustrating to all concerned, particularly since only two of the three objectives can be met at any one time, implying a highly contentious political process of forging a consensus. For indeed if one seeks to

achieve equity coupled with economic and budgetary control, doctors may have less freedom to charge on a fee-for-service basis—a potentially explosive political issue in the Philippines. On the other hand, if equity and freedom of service providers were the norm, then health costs can be expected to rise steeply.

Yet health insurance programs are going concerns which cannot stop operating

until a health-financing policy with clear objectives is formulated. To stay relevant regardless of the health-financing policy adopted, efforts to promote health insurance should focus on activities that will boost efficiency and effectiveness, such as improving systems and procedures, training manpower, containing costs, ensuring the quality of care, and pilot-testing public financing strategies for low-income groups using private providers/insurers.

REFERENCES

- Alfiler, Ma. Concepcion P. "Health Financing in the Philippines: A Review of the Literature." 1986.
- _____. "Partnership and Responsibility in Financing Health Activities: Non-Government and Private Voluntary Organizations in the Philippines." Paper commissioned by the World Health Organization as background document for the Technical Discussion, 40th World Assembly, 1986.
- _____. "Health Maintenance Organization as an Alternative Mode of Financing and Delivering Health Care in the Philippines: Some Preliminary Findings." Paper presented at a seminar sponsored by the Philippine Institute for Development Studies, May 9, 1989.
- _____. "Prepaid Managed Health Care: The Emergence of Health Maintenance Organizations as Alternative Financing Schemes in the Philippines." Paper presented at the International Health Policy Conference, Manila, July 31 - August 4, 1989.
- Center for Research and Communication. *Philippine Health Care Factbook 1990*. Manila: Southeast Asian Science Foundation, 1991.
- Cooper, M.H., and Devlin, N.J. "Situation Analysis and Economic Assessment of the Philippine Health Service." 1990.
- Day, Roger C. "HMO Regulation in the Republic of the Philippines: Trip Report." 1990.
- Executive Order 105. "Amending Certain Sections of Presidential Decree 1591 to Strengthen the Philippine Medical Care Plan," December 1986.
- Executive Order 106. "Restructuring the Medical Care Benefits Under the Philippine Medical Care Plan," December 1986.
- Executive Order 269. "Amending Presidential Decree 1519 Entitled 'Revising the Philippine Medical Care Act of 1969,'" July 1987.
- Executive Order 344. "Increasing the Benefits for Medical/Dental Practitioners Fees Provided for Under the Philippine Medical Care Plan," January 1989.
- Executive Order 365. "Increasing Benefits and Monthly Contributions Under the Philippine Medical Care Plan and Providing for a Health Financial Assistance Program," August 1989.
- Executive Order 402. "Granting Medical Care Benefits to SSS Old-Age Pensioners and Their Dependents," May 1990.
- Executive Order 441. "Increasing Medicare Benefits Under the Philippine Medical Care Plan," January 1991.
- Griffin, C., et al. "An Analysis of the Philippine Medicare System." 1985.
- Group Health Association of America. "Utilization Management Techniques in Prepaid Group Practice: Health Maintenance Organizations." Washington, D.C., 1983.
- HEWSPECS and Intercare Research Foundation Inc. "Pilot HMO Project: Final Report." 1990.
- Hsiao, William C. "Think Before You Leap: Lessons the Philippines Can Learn from Developed Nations in Health Care Financing." Paper presented at the National Conference on Health Care Financing Systems in the Philippines, Manila, March 22, 1991.
- Insurance Commission. *Annual Report of the Insurance Commission, 1989*. Manila: Department of Finance, 1989.
- Integrated Health Care Services Inc. (INTERCARE). "Health Care Financing in the Philippines." Asian Development Bank and East-West Center, 1987.
- International Labor Organization. "Medical Care Benefits—Phase 1: Preliminary Report to the Social Security System, Republic of the Philippines, 1989."
- _____. *Employment and Manpower in the Philippines: A Sectoral Review Report, 1990*.
- Jeffers, James R. "Draft Terms of Reference for Medicare Expansion and Revision: Policy Research and Analysis." 1990.
- Lewis, Maureen A. "The Private Sector and Health Care Delivery in Developing Countries: Definition, Experience, Potential." Prepared by the Resources for Child Health Project (REACH). Arlington, Virginia: John Snow Inc., 1988.
- Long and Morton. *Principles of Life and Health Insurance*. 2nd ed. Atlanta, Georgia: Life Management Institute LOMA, 1988.
- Lugue, Francisco M. "An Analysis of the Impact of Compulsory Health Insurance on Health Care Demand." Unpublished undergraduate thesis. Center for Research and Communications, 1988.
- McGreevy, William. "Social Security in Latin America: Issues and Options for the World Bank." Washington, D.C., 1990.
- Nolledo, Jose N. *Labor Code of the Philippines*. Manila: National Book Store, 1990.
- Philippine Institute for Development Studies. *Survey of Philippine Development Research III*. 1989.
- Philippine Medical Care Commission. "Seminar Workshop for the

Development of a National Health Insurance Program for Filipinos." 1989.

Presidential Decree 1519. "Revised Philippine Medical Care Act," June 1978.

Presidential Decree 626. "Employees Compensation and State Insurance Fund (As Amended)," 1989.

Reverente, Benito R., Jr. "Recurrent and Future State of Prepaid Health Care in the Philippines." *Philippine Journal of Internal Medicine*, Vol. XXVI, No. 6 (November-December 1988), 377-90.

Rock, Alan S., and Treasure, Kerry G. *Health Maintenance Organization: Critical Performance Measures*. Monograph Series, Vol. III. Maryland: Birch and Davis Associates Inc.

Ron, Aviva, et al. *Health Insurance in Developing Countries: The Social Security Approach*. Geneva: International Labor Organization, 1990.

Saunders, Margaret K. "Analysis and Summary of World Bank Activity in Health Insurance." Working paper of the Economic Development Institute of the World Bank. 1989.

Solari, Alfredo. "Evaluation of the Philippine Medical Care System: Trip Report." Prepared by the Resources for Child Health Project (REACH). 1988.

Solon, Orville, and Herrin, Alejandro. "Basic Issues in Health Care Financing in the Philippines." Paper presented at the Policy Conference on Health Care Financing, Manila, March 22, 1991.

Tan, Jose Antonio R. III. "An Analysis of the Employment Compensation State Insurance Fund." Unpublished undergraduate thesis. University of the Philippine School of Economics, 1990.

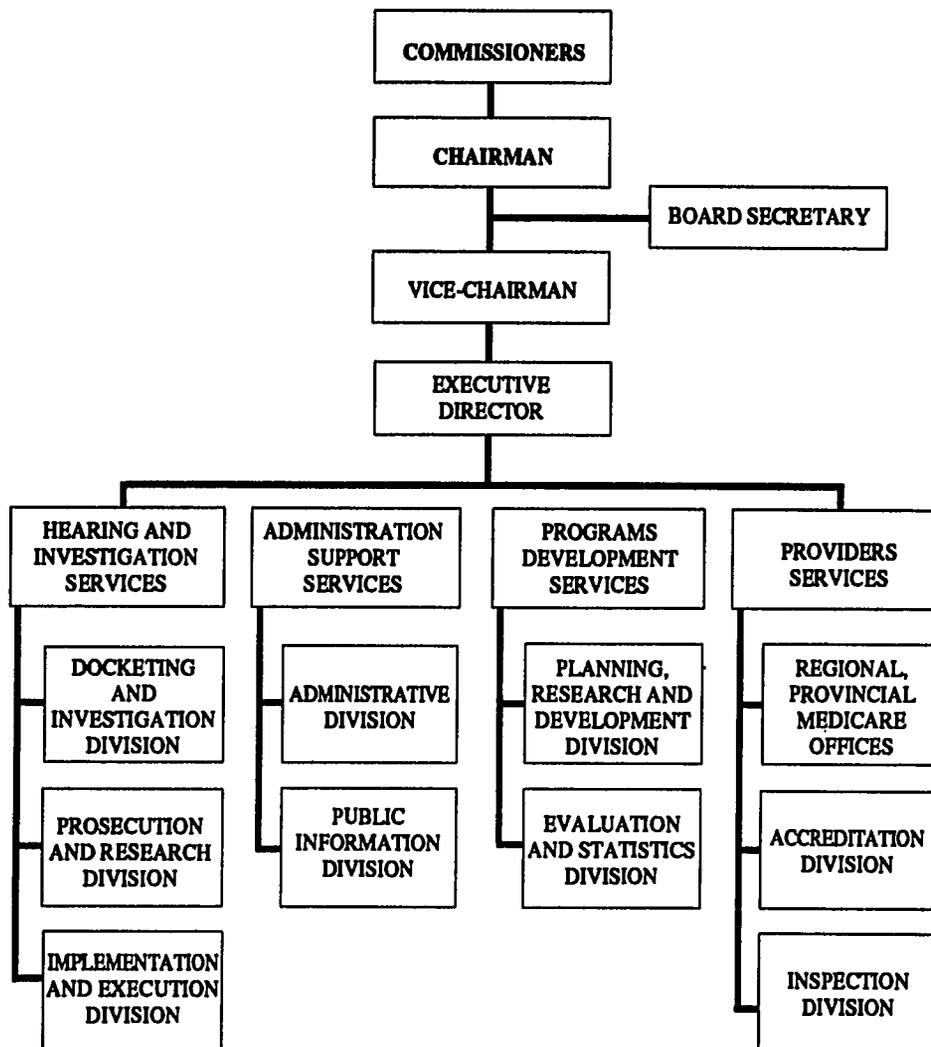
U.S. Agency for International Development. "Health Finance Development Project, 1990: Project Identification Document (492-0046)." Manila, 1990.

U.S. Department of Health and Human Services. "International Comparison of Health Care Financing and Delivery: Data and Perspectives." *Annual Supplement of the Health Care Financing Review*. 1987.

World Bank. "Financing Health Services in Developing Countries: An Agenda for Reform." 1987.

ANNEX A

**PHILIPPINE MEDICAL CARE COMMISSION
ORGANIZATIONAL CHART**
(Under E.O. 119, s-87 and R.A. 6758)



ANNEX B

PERSONS INTERVIEWED

Name	Position	Company
Rafael Bantayan Jr., M.D.	Senior Vice President	Health Maintenance Inc.
Ernesto Benesa, M.D.	Senior Vice President	Fortunecare-HMO
Reynaldo Centeno	First Vice President and Actuary	Philamlife Insurance Co.
Carlos Crisostomo, M.D.	Medical Director Chief Medical Officer	Fortunecare-HMO Healthkard Inc. Hospital
Dolores Gicaro	Vice President and Actuary	Ayala Life Assurance Inc.
Eduardo Giron	Division Manager	Family Medicare
Alfredo Gatmaitan, M.D.	Medical Director	Family Medicare
Teofilo Hebron, Ll.B.	Commissioner Deputy Executive Director	Philippine Medical Care Commission Employees Compensation Commission
Salvador Lazo, M.D.	President	Healthkard Inc.
Orlando Manalang	Assistant Manager	Family Medicare
Ramon Panotes	Vice President	Philamlife Insurance Co.
Razul Requesto	President	Pamana Goldencare Inc.
Benito Reverente, M.D.	President President	Philamcare Inc. AHMOPI
Ernesto Rufino	President	Health Maintenance Inc.
German Zapanta	Executive Vice President	Fortunecare-HMO